Worklife

Task Force

Renewing our Commitment to Nurses

A Report to the Minister of Health
from the Worklife Task Force

101-05878/

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The completion of this strategy and report has been made possible only through the support and assistance of many persons. The Worklife Task Force would like to acknowledge and express thanks to:

- The Regional Health Authorities,
- The nursing regulatory bodies,
- Nursing stakeholders,
- Sandra Stec and Christina Whittaker, Coordinators of the Worklife Task Force
- Workforce Policy and Planning Branch, Manitoba Health; and above all
- The nurses of Manitoba who granted the Task Force their valuable time and input.

The contribution of all is most highly appreciated.

Letter of Transmittal

Worklife Task Force
C/o Workforce Policy and Planning Branch
Manitoba Health
Room 4041
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Winnipeg, Manitoba
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April 9, 2001

The Honourable Dave Chomiak
Minister of Health
302 Legislative Building
450 Broadway
Winnipeg MB R3C 0V8

Dear Mr. Chomiak:

The Worklife Task Force is pleased to provide you with the outcomes of the Worklife Task Force.

Over the life of the Task Force, the members established and oversaw a multi-level strategy to examine issues that affect nurses' working conditions and their workplace environment.

The report from the Task Force is comprised of several parts: background information, methodology, and key findings.

I would like to thank the members of the Task Force, the Regional Health Authorities, the nursing regulatory bodies, the nursing stakeholders, and above all, the nurses who granted the Task Force their valuable time and input to contribute to this process. The contribution of all is most highly appreciated.

Yours sincerely,

Anne Wright

Anne Wright
Chair, Worklife Task Force

Executive Summary

The Minister of Health established the Worklife Task Force in March 2000 as one component of a five-point plan to address nursing issues. The mandate of the Task Force was to examine issues that affect nurses' working conditions and their workplace environment.

The Task Force consisted of three nurse members. Members include Brenda Lesyk, RN, of Warren; Patricia Cockburn, RN, of Neepawa; and Anne Wright, chair of the Task Force, a retired registered nurse, from Brandon.

Feedback from active practicing nurses was solicited via a mailed survey and general meetings. The input of stakeholders was requested via invitations for written submissions to the Task Force.

A total of 13,946 surveys were mailed. As of November 26, 2000 the following numbers of surveys were returned:

RPN 176 of 1,018 distributed, a response rate of 17.3% of all RPNs

LPN 399 of 2,228 distributed, a response rate of 17.9% of all LPNs

RN 1,993 of 10,700 distributed, a response rate of 18.6% of all RNs

Unknown = 2 (sent by fax)

Total = 2570

The Task Force held open meetings with nurses in each Regional Health Authority (RHA) over a seven-week period in the fall of 2000. Meetings were held in 34 sites across the province, with conference calls to three others. A total of 402 people attended the regional meetings, representing three percent of active practicing nurses.

To consult with larger groups also knowledgeable about the concerns of nurses, submissions were invited from employers, unions, and providers of education. Submissions were requested from 13 organizations, and nine were received.

The Task Force identified and summarized the workplace issues identified from all three sources of information. Pilot projects and recommendations to address issues were identified. All three sources of information demonstrated consistency in regards to the general nature of the issues concerning nurses' worklife. The issues were not prioritized, as priorities differed nurse-to-nurse, site-to-site and region-to-region. Twenty-five issues were identified under five broad categories: staffing, working conditions, education, community health and valuing.

Recommendations

Staffing

Staffing guidelines

Recommendations:

i) Manitoba Health review and revise staffing guidelines (nursing and non-nursing) in collaboration with the Regional Health Authorities (RHAs) and staff nurses to reflect changes in acuity of clients and intensity of care in acute and long-term facilities, and in the community.

ii) Adjustment of RHA budget to reflect changes in staffing guidelines.

iii) Manitoba Health and the Regional Health Authorities of Manitoba (RHAM) determine the applicability and/or use of workload and acuity tools in relation to funding.

iv) Limitations on the workload of community health care providers are supported.

v) Baseline funding for fiscal year 2002-2003 include relief/vacancy coverage for community health staff.

Lack of flexibility of scheduling

Recommendations:

i) The RHA, union and staff work collaboratively to investigate and implement creative solutions to flexible scheduling within the collective agreement.

ii) Manitoba Health, in collaboration with the Provincial Human Resources Network, investigates provincial purchase of a scheduling software program.

Nurses performing non-nursing functions

Recommendations:

i) Nurses and RHAs identify the needs for increased support staff and submit a proposal to Manitoba Health in one year, evaluating staff satisfaction.

ii) Manitoba Health provide additional funding for increased support staff, not from current nursing budgets.

iii) The RHAs, in collaboration with Manitoba Health, establish mechanisms to evaluate the rate and reason for patient readmissions.

Aging work force/retiring nurses

Recommendation:

i) The Labour Relations Secretariat and Health Employee Pension Plan (HEPP) work collaboratively to address and consider pension issues, i.e., buy back of pension years.

Integration and mentoring of new nurses

Recommendations:

i) Regional/facility development of orientation programs that are comprehensive and tailored to the needs of new staff as a standard.

ii) The Nurses Recruitment and Retention Fund Committee be asked to develop a template for a standardized formal mentoring and preceptor program for new practitioners:

   a) The Regional Recruitment and Retention Committee implement and evaluate the program.

b) Manitoba Health provide funding to support mentor/preceptor programs and orientation of the new graduate.

c) Tangible rewards and/or recognition are provided by the workplace for preceptors/mentors.

Geographically isolated areas

Recommendations:

i) Manitoba Health, nursing staff, community, the union and the northern RHAs work with staff and management to determine the best methods of recruitment and retention, investigating:

a) Financial incentives to assist with the recruitment of staff.

b) Financial incentives to assist with the retention of staff.

c) Collaboration with Manitoba Education and Training re: tuition reimbursement for local community members to enter nursing programs.

d) Availability of housing for staff and students.

e) Means to attract students for their senior practicum, including financial support for accommodation.

f) Adequate living conditions, with equity between subsidized rent and lack of subsidies for home purchase.

g) Promotion of regional differences that may be incentives for attracting staff, i.e., schooling, social activities, wildlife.

ii) The RHAs bring to the attention of community leaders the issues of recruitment and retention of all health professionals, not just nursing.

iii) Return of service agreement for employer sponsorship of formal education.

On call for small rural/ northern facilities

Recommendations:

i) Discussion at facility/regional level re: the needs and requirements for on-call systems in small/rural northern facilities.

ii) Provide additional funding to the RHAs to support an on-call system.

Equivalent Full-Time (EFT) positions in rural and northern nursing

Recommendations:

i) RHAs explore with nurses the potential for higher EFT rotations.

ii) Explore the need for full-time float positions.

Working Conditions

"Nursing leaders" specific to unit or practice setting

Recommendations:

i) The RHAs work with staff nurses to identify the requirement for additional site-based nursing leaders, including evening/night/weekend nursing supervisors.

ii) Implementation be supported by Manitoba Health financially and otherwise.

Appropriate utilization of the Emergency Room (ER)

Recommendations:

i) The RHAs review the role of emergency rooms and the use of ER nurses with the goal of implementing strategies to reduce inappropriate use of the ER.

ii) Provide public education regarding appropriate use of emergency facilities. A model may be found in the recent BC HealthGuide handbook (http://www.hlth.gov.bc.ca/cpa/newsrel/2001/087.html)

iii) A central bed registry is developed for emergent rural referrals to tertiary care centres for after hours/weekends/ holidays.

Equipment

Recommendation:

i) Manitoba Health provide adequate capital and operating funds to each RHA for timely maintenance and updating of equipment.

Provincial Employee Assistance Program (EAP) and Critical Incident Stress Management Program (CISMP)

Recommendations:

i) Implementation of a province-wide and accessible EAP funded by Manitoba Health.

ii) Implementation of a province-wide and accessible Critical Incident Stress Management Program (CISMP) funded by Manitoba Health.

Staff security and safety

Recommendations:

i) Encourage the Manitoba Government to lobby the telecommunications industry to expand cellular phone coverage within rural and northern Manitoba.

ii) Winter survival kits are supplied for nurses in jobs requiring travel in rural/northern areas.

iii) A means for contacting persons in an emergency while on work-related travel is provided, such as a cell phone.

iv) Development of regional criteria for vehicle assignment taking into consideration personal and vehicle safety, and environment/geography.

v) Utilization of internal and external security systems, including on-site security personnel, volunteers or cross-trained personnel as applicable be reviewed and criteria and standards set, implemented and evaluated by the Workplace Health and Safety committees.

vi) Workplace Health and Safety Committees investigate the availability of parking as it relates to a safe environment.

Availability of food services for clients and staff

Recommendation:

i) The RHAs explore the expansion of food services for staff, clients and visitors, including appropriate meal times for clients

Day care

Recommendation:

i) Explore the need for additional subsidized day care spots in collaboration with Manitoba Family Services and Housing.

Pilot project:

i) The Pas may be a potential pilot project site for exploring 24-hour day care.

Education

Current, accessible, affordable continuing education

Recommendations:

i) Continuing education should be a priority in the provision of additional funding and resource allocation to the RHAs:

- Updated and on-line/computerized regional policy and procedure manuals, with financial support from Manitoba Health for capital and human resource costs.
- Manitoba Health explore with RHAM the potential for, and fund as necessary, the placement of standardized nursing procedures on a Web site to support immediate province-wide accessibility to current client care procedures.
- Ongoing financial support for continuing education is provided annually through the Nurses Recruitment and Retention Fund.

ii) Manitoba Health explores ongoing mechanisms for funding of educational programs beyond 14 days such as the Operating Room Course and Intensive Care Courses.

iii) Base budgets appropriately reflect continuing educational needs, including sufficient funding for regional or facility programs, including financial, human and educational resources.

iv) Academic educators enhance the content and delivery of distance education both within undergraduate, graduate and continuing education programs.

v) RHAs develop a formal interview process so that participation in continuing education programs can be recognized and appropriately factored into awarding of posted positions.

Pilot project:

i) Demonstration project for the development of updated and on-line/computerized regional policy and procedure manuals in Marquette RHA. Marquette RHA currently has network capabilities. Project to be fully funded by Manitoba Health for dedicated resources. Evaluation of costs, resources and outcomes after one year for possible application in other RHAs.

Educational resources

Recommendations:

i) Manitoba Health, in consultation with RHAM, develops and maintains a centralized provincial pool of current client education materials on-line.

ii) Nurses have access to computers with on-line capability at close proximity to nursing activity, with corresponding education re: computer utilization.

iii) Manitoba Health identifies and makes available key health sites on the Internet that provide reputable and valid health information.

iv) Manitoba Health support implementation and maintenance costs of the above recommendations.

Community Health

Facilities for community health

Recommendations:

i) Review of all community health facilities by the RHAs.

ii) Secure adequate, appropriate space for community health staff with ergonomically appropriate design in consultation with staff nurses.

iii) Due to the safety issues surrounding some environments, capital monies must be released outside of the capital budget process.

iv) Other requirements may be addressed in the capital budget process for 2003-2004 (given budgeting cycle).

Additional provincial community health programs

Recommendations:

i) The introduction of new community health programs is slowed to allow for time to "catch up".

ii) The RHAs are included in the preliminary planning for community programs by Manitoba Health allowing for the coordination of resources and consideration of process.

iii) Manitoba Health revisits the establishment of a Public Health Nursing Branch.

iv) New community programs must be introduced with additional and appropriate resources, supports and staff as part of a long-term provincial strategic plan.

Home Care

Recommendations:

i) The RHAs, Manitoba Health and the union work towards permanent EFTs in Home Care.

ii) Explore in rural areas the expansion of Home Care programming, such as Home Intravenous program.

Valuing

Communication

Recommendations:

i) Incorporate local/regional solutions for effective communication between staff and all levels of management.

ii) Enhance communication to staff pertaining to the role, decision-making

process, and accountability of Manitoba Health and the RHAs.

iii) Nurses are formally included in decision-making and consultative roles within the provincial and national governments.

iv) Organizational structures support direct involvement by nurses in decision-making that impacts on their work, with reimbursement for time spent outside of work hours supported financially by Manitoba Health.

v) Explore the feasibility of developing a mechanism to publicly identify current posted nursing positions in Manitoba. This could possibly be a responsibility of the Provincial Recruitment and Retention Committee in collaboration with the Provincial Human Resources Network.

Value and recognition

Recommendations:

i) Consideration be given to paid coffee/meals for staff on overtime or short notice shifts, or on statutory holidays.

ii) All new capital projects include staff lounges, which would be dedicated to staff use only.

iii) Money from the Provincial Recruitment and Retention fund is allocated to each region for the discretion of managers to provide acknowledgment for nursing staff.

iv) Each RHA investigate the opportunity for staff wellness initiatives based on staff feedback.

Image of the profession of nursing and of the health care system

Recommendations:

i) The Provincial Nursing Resource Task Force and/or Provincial Recruitment and Retention Committee be approached to develop a media/ marketing campaign that:

a) acknowledges the role of nursing;

b) provides education regarding the impact of the nursing shortage;

c) addresses nurse abuse and its effects; and

d) enhances public awareness about the responsibilities and decision-making inherent in nursing practice.

Recognize and utilize nurses to their fullest potential and autonomy

Recommendations:

i) Nurses are provided with specific rationale regarding the delay in passing the Registered Nurses Act.

ii) Utilization of nursing roles and skills within regions to their fullest potential reflective of current educational curriculums.

iii) Participation in committees or professional activities be compensated and factored into opportunities for career advancement.

Differential attention to retention and recruitment

Recommendations:

i) Investigate retention of benefits when moving between RHAs or employers.

ii) Given the current national and international marketing campaigns, the Provincial Recruitment and Retention Committee develop aggressive retention strategies.

Additional Recommendations

Local solutions

Recommendation:

i) Local consultation including RHAs, nurses and community leaders as appropriate, occurs on implementation strategies to improve worklife issues.

Implementation of Worklife Task Force recommendations

Recommendations:

i) The report from the Advisory Committee on Health Human Resources to the Conference of Deputy Ministers/Ministers of Health in October 2000 recommended the formation of provincial Nursing Advisory Committees. Until the formation of this committee, the Provincial Nursing Resources Task Force be requested to consider:

   a) Investigating the feasibility and accountability of implementing the recommendations;

   b) Overseeing the implementation of this report;

   c) Determining follow-up evaluation; and

   d) Exploring linkages with the Office of Nursing Policy to facilitate sharing of initiatives and strategies.

   The Provincial Nursing Resources Task Force consists of representatives from regulatory bodies, educational institutions, unions, employers and health care aides.

ii) That there is open and full collaboration and resource distribution between RHAs and nursing organizations on the study, development, implementation or evaluation of strategies to address worklife issues via the Provincial Nursing Resources Task Force or its successor.

Task Force strategy

Recommendations:

i) A mechanism for request of the survey analysis per region or professional designation is made available through Workforce Policy and Planning Branch, Manitoba Health

ii) The Taskforce report is made publicly available by May 15, 2001 through a variety of mechanisms such as a Web page or through the regulatory bodies.

iii) A written copy of the Executive Summary in both official languages should be made available to nurses upon request to the Workforce Policy and Planning Branch of Manitoba Health.

iv) Future initiatives consider clarity and accessibility of communication.

v) Future surveys include self-addressed stamped envelopes and utilize standardized survey instruments with proven reliability and validity.

Long-term human resource planning and forecasting

Recommendations:

i) Long range human resource planning and forecasting model of nursing be coordinated and implemented provincially by Manitoba Health and RHAM.

ii) The utilization of support staff and interrelated health occupational groups should be considered in long-term human resource planning.

Part 1:

Introduction

The Minister of Health established the Worklife Task Force in March 2000 as one component of a five-point plan to address nursing issues (see appendix A: News release – Five-point plan announced to address nursing issues). The mandate of the Task Force was to examine issues that affect nurses' working conditions and their workplace environment:

- Identify factors contributing to job dissatisfaction;
- Identify causes of workplace and personal stress for nurses (such as a lack of mentors, limited or no input into decision-making, increased workload demands, and caring for children and elders at home);
- Develop proposals to address the most significant issues affecting job satisfaction; and
- Oversee the development and implementation of pilot projects to evaluate initiatives that may improve job satisfaction (see appendix B: News release – Task Force named to examine working conditions for nurses).

The fourth role was determined to be more appropriately monitored and evaluated by those who develop and implement the pilot projects. The Task Force began meeting in June 2000, and over the summer designed a plan to gather comprehensive feedback about workplace issues from the perspective of nurses and stakeholders. The plan consisted of three methods of input: regional meetings, mailed surveys and written submissions from stakeholders.

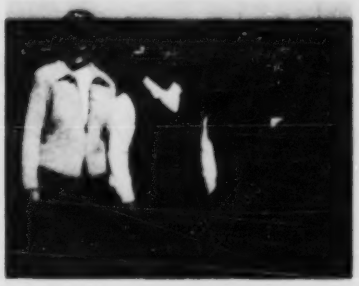
A variety of reports, research and literature address the many background issues related to the worklife of nurses, such as the restructuring of health care, the aging of the nursing workforce, the aging of the population, the nursing shortage and general issues related to recruitment and retention (see the bibliography and other related literature for background information).

The recommendations noted in the following pages represent the views of the participants in the surveys, regional meetings or submissions. This report summarizes these findings and presents recommendations from the Task Force.

Members

The Task Force consisted of three nurse members. Members included Brenda Lesyk, RN, of Warren; Patricia Cockburn, RN, of Neepawa; and Anne Wright, chair of the Task Force, a retired registered nurse, from Brandon. The biographies of the members can be found in the news release in appendix B.

• ***The plan consisted of three methods of input: regional meetings, mailed surveys and written submissions from stakeholders.***



(L–R) Patricia Cockburn, RN, Anne Wright and Brenda Lesyk, RN.

Part 2:

Methodology

Feedback from active practicing nurses was solicited via a mailed survey and general meetings. The input of stakeholders was requested via invitations for written submissions to the Task Force.

For the purpose of this report, the term "nurse" refers to registered nurses (RNs), registered psychiatric nurses (RPNs) and licensed practical nurses (LPNs). The term "client" will be used to describe the recipients of health care, and "RHA" to describe the employer, whether that employer is a Regional Health Authority or a non-devolved site.

Regional meetings

Locations and times

- ***A total of 402 persons attended the regional meetings, representing three percent of active practicing nurses.***

The Task Force held open meetings with nurses in each Regional Health Authority (RHA) over a seven-week period in the fall, 2000. Meetings were held in 34 sites across the province, with conference calls to three others (see appendices D and E for a schedule and map of the meetings). An outline of the towns in which meetings could be held was presented to each RHA with invitations for modifications of location. Scheduling considerations included maximizing the accessibility of nurses, both in location and time, completion of travel before the onset of winter weather, and desire for timely completion of the regional meetings and this report.

The meetings were open to all RNs, RPNs and LPNs practising in Manitoba. Although all nurses appeared to communicate openly in meetings that included both staff nurses and those in management positions, it became apparent to the Task Force, and verified by participants, that staff and management would each be more open and comfortable meeting separately with the Task Force. As such, after the first week of regional meetings the option for management staff to meet separately with the Task Force was extended to each RHA.

The open meetings began with a standardized five-minute introduction to the Task Force, including the members, mandate and format of the meetings. Nurses were invited to stay for the duration of the two-hour meetings, or leave as needed. Nurses were asked to discuss any non-contractual issues that related to their work satisfaction or dissatisfaction.

Notice of meetings

The meetings in rural Manitoba were advertised via posted notices distributed by the Regional Health Authorities to health care agencies where RNs, RPNs and LPNs may work, in both the community and the facility (see appendix F for notice).

In Winnipeg, the Task Force sent notices for internal distribution to the Chief Nursing Officer of each acute care facility; and to each long-term care facility and community health office or agency. The WRHA community, home care and long-term care programs further supported circulation of notices via their internal fax communication systems.

Attendance at meetings

A total of 402 persons attended the regional meetings, representing three percent of active practicing nurses (see appendix F for meeting attendance). For the purposes of analysis, RPNs who are also RNs were counted once as RPNs. Forty-eight or 12% of those who attended were management staff. For purposes of this report, managers refers to any nurse in a position of supervision, from "head nurse" or "unit manager" or program, community or district

managers and above. The titles, responsibilities and scope of managers were unique to each region and health care program or facility. The group meetings included two conference calls to three geographically isolated facilities. Many nurses attending indicated that they represented the thoughts and opinions of several nurses who were unable to attend. While statistics regarding the workplace setting of participants were not kept, the Task Force was pleased about the meaningful participation across all levels of nursing practice settings and roles.

Overall attendance decreased as the tour progressed. No specific factor could be identified, however participants suggested a number of potential influences. These included:

- The distribution of surveys midway through the regional meetings with the surveys seen as a sufficient source of feedback;
- Anger at the Task Force for not including self-addressed stamped envelopes for return of the survey; and
- Stakeholder requests for feedback from their members for their written submission mid-way, another perceived means of feedback.

Nurses who did participate in the general meetings additionally provided feedback from peers that their non-attendance was also related to skepticism from lack of action on previous reports and lack of feedback on previous assessments of worklife or health care reorganization.

Survey

Development of survey

The Task Force developed a survey specifically for distribution to Manitoba nurses. Questions were based on previous tools used in other studies. The survey was limited to two pages to enhance ease of completion. As seen in appendix H, the survey consisted of eight demographic questions, 15 questions with a five-point Likert scale ranging from agree to disagree, two "yes - no" questions, two multiple choice and one open-ended question.

Distribution of survey

Self-administered anonymous surveys were distributed to all active practicing RNs, LPNs and RPNs in Manitoba through the three nursing regulatory bodies. Surveys were colour coded to identify professional designation. Costs were reimbursed through the Task Force.

Some nurses not in roles of direct care provision within facilities informed the Task Force that they felt that many of the questions were not reflective of or pertained to their area of practice, and thus they did not feel that they could answer the questions.

Further feedback from nurses in regards to the survey included:

- lack of contact information for any questions;
- lack of clarity re: purpose; and
- lack of alternate means of return other than mailing, such as via fax or drop-off boxes.

Survey analysis

The Manitoba Nursing Research Institute was contracted to provide survey analysis. Data were analyzed per professional designation, and as requested by the RHAs, by each RHA. Open-ended responses to the final question were pre-coded according to developed themes.

Sample characteristics

A total of 13,946 surveys were mailed. As of November 26, 2000 the following numbers of surveys were returned:

RPN 176 of 1,018 distributed, a response rate of 17.3% of all RPNs

LPN 399 of 2,228 distributed, a response rate of 17.9% of all LPNs

RN 1,993 of 10,700 distributed, a response rate of 18.6% of all RNs

Unknown = 2 (sent by fax)

Total = 2570

- ***The Task Force was pleased about the meaningful participation across nursing practice settings and roles.***

Surveys continued to be accepted three weeks after the suggested return date. Data entry was completed on November 26, 2000. Following that date, nine surveys were returned.

The majority of the respondents (77%) indicated that they provided direct care in contrast to "other" (22.2%). Ninety-two percent of the respondents were female, 3.8% male, and 4.1% did not indicate a gender. Further sample characteristics can be found in Appendix I.

Many nurses work more than one nursing job in order to work full-time. Their survey responses could differ depending on which job the nurse used as a reference for completion. Some nurses also indicated confusion between the purpose and potential outcome of the Task Force survey versus previous surveys.

The Task Force recognized the importance of gaining feedback into worklife issues from those who had recently left nursing. The submission by the Manitoba Association of Registered Nurses (MARN) indicated that the Manitoba Nursing Research Institute (MNRI) and MARN gathered this information in a survey of non-practicing registered nurses in June 1999. The MARN/MNRI survey looked at the reasons for leaving practice, the reasons for not returning to nursing and support needed to return to practice. The final report is in progress.

Written submissions from key nursing organizations/ stakeholders

To consult with larger groups also knowledgeable about the concerns of nurses, submissions were invited from employers, unions and providers of education. The resources of the Task Force and request by the Minister for a timely report prohibited an open invitation for submissions. The Manitoba Council of Health Care Unions was contacted to identify those unions that were most representative of nursing. Submissions were requested from 13 organizations, with nine received. Please see appendices K and L for the letter of submission, and list of organizations invited to participate.

Part 3:

Key Findings

The following section of this report will identify and summarize the workplace issues identified from all three sources of information. Pilot projects and recommendations to address issues are discussed. All three sources of information demonstrated consistency in regards to the general nature of the issues concerning nurses' worklife. The issues are not discussed in priority, as priorities differ nurse-to-nurse, site-to-site and region-to-region.

Staffing

Staffing guidelines

The overwhelming stress and workload of many nurses was identified in most practice settings. Overworked and overburdened nurses are working in conditions that they perceive as unsafe, however there are often no or minimal vacant positions in those same work settings. Staffing guidelines set by Manitoba Health were perceived in many areas to prohibit the posting of additional nursing positions necessary for client safety. Furthermore there was a consistent and clear perception that funding to the RHAs for staffing does not match the staffing guidelines.

Current staffing guidelines were not seen as reflecting the increased acuity in both acute and long-term care; potential as well as actual problems; outpatient use of rural emergency rooms; mentoring of students; and facilities with < 50 beds.

- There is confusion regarding the existence or utilization of staffing guidelines for facilities with > 50 beds on the part of staff nurses and management.
- Waiting lists to contact community health care providers are growing, with RHAs beginning to consider capping for the first time the number of clients seen by community health care providers.
- Many personal care homes have reduced staffing on weekends, a time when nursing needs are perceived to be greater due to decreased numbers of support and professional staff and greater family visiting.

Analysis of staffing patterns was required to move beyond number of in-patient days to reflect the complexity of nursing care. Such a measure would include both qualitative and quantitative considerations such as the amount of support staff needed, time with families, complexity of care, and non-nursing functions. Perceptions by nurses of adequate staffing also impact on how nurses perceive that they are valued or treated as knowledgeable professionals by their employers. Dr. L. O'Brien-Pallas, recipient of the CHSRF/CIHI Chair Award for Nursing Human Resources, has done extensive research on measuring nursing workload.

The inability to provide holistic quality client care appeared to be the greatest cause of dissatisfaction for nurses. In some areas, this frustration is leading to an increase in horizontal aggression between staff. Staff feel that all they do is crisis management and that they are unable to move from crisis intervention to health promotion and prevention. To retain nurses, employers must ensure that nurses have the opportunity to provide satisfying and quality care, and gain control over their workload. During the general meetings, some nurses indicated working casual or part-time allowed them to pick up extra shifts according to their needs, thus attaining some control over their workload. Nurse managers are increasingly responsible

• To retain nurses, employers must ensure that nurses have the opportunity to provide satisfying and quality care, and gain control over their workload.

for regional activities, taking them away from the work site where they are felt to be needed to address such issues.

Practice environments in the community have also changed dramatically over the last several years. As indicated in the submission by the Registered Psychiatric Nurses Association of Manitoba (RPNAM) in their report "Impact of Mental Health Reform on Psychiatric Nursing" in addition to the changing paradigms of care, mental health clients have increasingly moved to the community, further diversifying the practice environment and competency requirements of the mental health practitioner.

The need for reinstatement of full-time positions was also a consistent theme within the submissions.

Recommendations:

- ***Job satisfaction included the opportunity to access the necessary support to do nursing work.***

i) Manitoba Health review and revise staffing guidelines (nursing and non-nursing) in collaboration with the Regional Health Authorities (RHAs) and staff nurses to reflect changes in acuity of clients and intensity of care in acute and long-term facilities and in the community.

ii) Adjustment of RHA budget to reflect changes in staffing guidelines.

iii) Manitoba Health and the Regional Health Authorities of Manitoba (RHAM) determine the applicability and/or use of workload and acuity tools in relation to funding.

iv) Limitations on the workload of community health care providers are supported.

v) Baseline funding for the fiscal year 2002-2003 includes relief/vacancy coverage for community health staff.

Lack of flexibility of scheduling

Nurses clearly indicated a need for more flexibility in scheduling. Greater flexibility would enhance the ability of nurses to accommodate an increase in work demands and work stress within their many community, educational and family obligations. Although this is predominantly a contractual issue, the Task Force recognizes the effect this issue has on worklife stress. Greater flexibility in scheduling may support nurses accepting additional hours. Examples of desired flexibility cited by nurses included staggered start times, job sharing, shift interchanges and shift flexibility such as permanent evening/night shifts if requested.

Recommendations:

i) The RHA, union and staff work collaboratively to investigate creative solutions to flexible scheduling within the collective agreement.

ii) Manitoba Health, in collaboration with the Provincial Human Resources Network, investigate provincial purchase of a scheduling software program.

Nurses performing non-nursing functions

Job satisfaction included the opportunity to access the necessary support to do nursing work. The decrease in support staff was seen as one of the reasons that nurses feel they "can never get on top or in control," further limiting the ability of nurses to provide nursing care and attain control over, and maintain, professional standards of practice. Nurses have been left to fulfill the responsibilities left vacant by the decrease in support staff, responsibilities inappropriate to the nurses' level of education, training and client need, an issue also identified in "The Nursing Strategy for Canada" (ACCHR, 2000). Added to the reductions in support staff (i.e., housekeeping, dietary, clerical) are the shortages in other health professional groups such as pharmacy and occupational/physical therapy and social work. Some of the non-nursing responsibilities that nurses have acquired included paperwork such as putting together charts, answering phones, housekeeping, dietary, pharmacy and calling in staff for sick time replacement. In the community, the lack of clerical resources and need for nurses to assume these tasks significantly impedes the ability to provide nursing care. The submission by the Manitoba Nurses Union (MNU) included a copy of "The Health Care Report" (Manitoba Nurses Union, 1998). This report stated that 73% of nurses consulted in Manitoba (n = 5000) said that their time on

patient care had decreased while their time on paperwork had increased.

Nurses feel that they "should be able to be case managers, do care planning, provide holistic care and do nursing duties," including discharge planning and client education. Nurses do not have the time or resources to provide family/client teaching, leaving nurses with the feeling that "they are not living up to their full potential." Due to nurses' limited ability to provide discharge or client/family education, nurses queried a possible increase in readmissions. Nurses' concerns regarding readmissions were also found in the submission by the MNU. The MNU 1998 Health Care Report indicated that 42% of nurses surveyed felt that re-admissions had increased over the past two years.

As reinforced by Keewatin Community College (KCC) in their submission, "The recent cardiac inquest at the Health Sciences Centre in Winnipeg demonstrates how the lack of influence and disempowerment experienced by nurses in a specialized area of care can lead to tragic consequences." The inclusion of nurses as political advisors and as appointments to the provincial government was also felt by KCC to further support empowerment within the profession and establish credibility for decisions made by government officials.

Question # 19 on the survey asked participants to choose, from a selection of items, the activities they "feel would increase (their) job satisfaction and/or reduce personal stress." Thirty-nine percent of the respondents included the selection of "increased clerical support" in their response.

The increasing acquisition of non-nursing roles has not been acknowledged in nursing staffing or on a personal level of appreciation. Augmenting the number and hours of support staff such as housekeeping, ward clerks, staffing clerks and aids through additional financing outside of the nursing budget would empower staff to provide care based on their professional knowledge and skills.

Recommendations:

i) Nurses and RHAs identify the need for increased support staff and submit a proposal to Manitoba Health, with evaluation of staff satisfaction in one year.

ii) Manitoba Health provide additional funding for increased support staff, not from current nursing budgets.

iii) The RHAs, in collaboration with Manitoba Health establish mechanisms to evaluate the rate and reason for readmissions.

Aging work force/ retiring nurses

The increasing age of nurses in Canada (CIHI, 2000) is well documented. It is of critical importance to retain the experienced nurses, particularly in the next five to 10 years, to assist with the mentoring of new graduates. Nurses in the older age groups have differential needs at work, and differing requirements to remain in active practice. Many nurses approaching retirement indicated a marked lack of interest in remaining employed on a full-time basis, struggling when asked what incentives might encourage them to continue working. Some indicated a willingness to consider working longer if they could continue to contribute fully to a pension while working part-time. Staff soon to retire also indicated that they might have been more willing to continue working if they had not had to work full-time due to pension requirements and become burned out at the end of their career.

According to the Health Employee Pension Plan (HEPP), once nurses meet their "magic 80", where age + years of service = 80, they can begin to collect their pension without financial penalty and work on a casual basis. If they had not met those criteria, basing a nurse's pension on the best five of the last 11 years of work was viewed as a requirement for continuing to work. Older nurses anecdotally reported an increased susceptibility to both work and non-work related illness and injury, indicating further that modification of workload, changes in shift rotation and/or choice of optimal shifts would provide additional incentives to remain in the work setting. The submission by the WRHA includes recommendations to "study retirement and pension issues and make adjustments as required" and to "develop strategies, which encourage the retention of the aging, mature nurse."

• The increasing acquisition of non-nursing roles has not been acknowledged in nursing staffing or on a personal level of appreciation.

• Older nurses anecdotally reported an increased susceptibility to both work and non-work related illness and injury, indicating further that modification of workload, changes in shift rotation and/or choice of optimal shifts would provide additional incentives to remain in the work setting.

Recommendation:

i) The Labour Relations Secretariat and Health Employee Pension Plan (HEPP) work collaboratively to address and consider pension issues, i.e., buy-back of pension years.

Integration and mentoring of new nurses

The decrease in the number of nursing graduates combined with the fatigue and stress of more senior and experienced nurses is perceived to have limited the tolerance for, and the understanding of the learning needs of new practitioners. Nurses soon to leave the profession "forget what it is like to be new." The opinion that "nurses eat their young" was commonly expressed with considerable concern for the new graduate.

At the same time, the period of time after starting a new job is seen as critical for retention into the profession. The casualization of nurses is a particular barrier for new practitioners who wish and require full-time positions to support integration into the profession and skills. New practitioners must be given the opportunity to "feel that they made the right choice in entering nursing" and to develop the confidence and skills that encourage retention into the profession. Research by the Canadian Council on Social Development (2000) found that "within three years of graduation, two out of 10 graduates will opt out of the profession." A survey of new graduates from the Manitoba Nursing Research Institute (2000), included in the submission by MARN, confirmed the desire of new graduates for full-time employment.

• Nurses are concerned about the ability, not just of themselves, but also of the health care system to provide the mentoring, orientation and support that new practitioners need and deserve.

• Preceptor programs were identified as one potential strategy to enhance integration into the workplace.

Orientation programs for new staff varied widely in content and duration, ranging from a limited number of days with a "buddy" to formal preceptor programs. The recent lack of new practitioners was cited by many as the reason for an abbreviated or non-existent orientation program. The workload of staff further limit both the ability of staff to provide mentorship and the time that the new practitioner is able to orientate before assuming full practice. A new regional component to some orientation sessions in the rural RHAs was viewed positively as assisting in the development of a wider view of their health care environment and identification and knowledge of regional peers and supports.

With health care cutbacks, health care provision has become reliant upon the expertise and ability of experienced practitioners. New practitioners will not be able to practice at the same level of expertise as those nurses close to retirement age. The new rural nurse may require even more time for orientation as he/she soon faces multiple responsibilities including charge, and may be the sole RN on duty on evenings and nights. The rural nurse is expected quickly to be "jack of all trades." Nurses are concerned about the ability, not just of themselves, but also of the health care system to provide the mentoring, orientation and support that new practitioners need and deserve.

A model that may be helpful for review and consideration is the "Mentoring Support Program for Nurses," part of the British Columbia's Health Action Plan. In BC, $3.78 million will be available over two years to health authorities to support nurses who engage in preceptorship and mentoring activities for new nurses, including lessening their patient-care load approximately 20%-30% during their participation (http://www.bchealthaction.org/nursementor.html).

Preceptor programs were identified as one potential strategy to enhance integration into the workplace. Characteristics of ideal preceptor programs included: a lengthy period of time; exclusion of the new staff from staffing levels; reduced and slowly graduated caseload for the mentor and new practitioner; early one-on-one buddying with one consistent staff member; and educational preparation for the preceptor. The workplace should demonstrate tangible support for preceptors, such as extra time back. The Grace General Hospital in Winnipeg provided such an example of a pilot preceptor program. In their submission, the WRHA included a recommendation to develop and provide supports for preceptors/mentors of students and new graduates and to develop strategies to ensure that the needs of the younger generation of nurses are heard and addressed.

Recommendations:

i) Regional/facility development of orientation programs that are comprehensive and tailored to the needs of new staff as a standard.

ii) The Nurses Recruitment and Retention Fund Committee be asked to develop a template for a standardized formal mentoring and preceptor program for new practitioners:

- The Regional Recruitment and Retention Committee implement and evaluate the program.
- Manitoba Health provide funding to support the template, which could include reduction of the workload of the mentor/preceptor and recognition of the new graduate over and above staffing guidelines.
- Tangible rewards and/or recognition are provided by the workplace for preceptors/mentors.

Geographically isolated areas

Geographically isolated areas experience unique issues in nursing worklife extending to personal and family quality of life, and available community services and lifestyle. Opportunities for socialization and activities outside of worklife for the nurse and his/her family may be less accessible or available, or different than in more urban settings. The unique incentives for nurses in such areas may be of benefit if more clearly expressed, such as a strong community; a good place to raise children; and northern or outdoor living. It was felt that nurses need to have a "sense of connection" to the community, otherwise they will leave. In their submission, the First Nations and Inuit Health Branch reinforced the benefit of a supportive and respectful community for retention and recruitment.

Persons who live in the community were thought to be more likely to return to the community to practice, if full-time work is available. Students are more likely to return if they are supported in their practicum experience, and can live in the community, i.e., available and affordable housing. Initiatives to attract students may directly assist in recruiting staff.

Dependence on the upcoming increase in supply of nurses was considered to be an inefficient and temporary way of addressing the maldistribution of nursing staff.

Interestingly, nurses noted that higher cost of basic foods such as milk, bread, fresh fruit and vegetables, which would improve the health of the population, is not subsidized and that the cost of alcohol, which is detrimental to good health, is constant throughout the province. "How can the province regulate the cost of alcohol but not the cost of milk?"

Suggestions for increasing the recruitment of local students into nursing included enhancing the opportunity for rural study and practice; financial remuneration or sponsorship of tuition in return for specified practice within the community. The difficulties and needs for the most remote areas are different than other rural areas, with the perception that their needs are overwhelmed and ruled by the larger southern population and subsequent focus.

In their submissions, the Keewatin Community College (KCC) and the Churchill RHA and First Nations and Inuit Health Branch recommended trips out of geographically isolated areas as a retention strategy. The Aboriginal Nurses Association of Canada/Medical Services Branch (2000), in their study of recruitment and retention, focused on six general issues:

- Ensure a reasonable work schedule with adequate time off;
- Provide management support;
- Good working conditions;
- Positive relationship with community leadership;
- Compensation; and
- Educational opportunities.

Similarly, the Churchill Regional Health Authority, Recruitment and Retention Working Group (1999) outlines a number of specific recommendations to enhance retention and recruitment appropriate to their region, including housing, financial incentives, employee recognition, community support and continuing education. The University of Manitoba reported that the northern site of KCC is

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the fastest growing Bachelor of Nursing site in Manitoba, with a 55% increase in enrollment over last year.

Recommendations:

i) Manitoba Health, nursing staff, community, the union and the northern RHAs work with staff and management to determine the best methods of recruitment and retention, investigating:

- Financial incentives to assist with the recruitment of staff.
- Financial incentives to assist with the retention of staff.
- Collaboration with Manitoba Education and Training re: tuition reimbursement for local community members to enter nursing programs.
- The availability of housing for staff and students.
- Means to attract students for their senior practicum, including financial support for accommodation.
- Adequate living conditions, with equity between subsidized rent and lack of subsidies for home purchase.
- Promotion of regional differences that may be incentives for attracting staff, i.e., schooling, social activities, wildlife.

ii) The RHAs bring to the attention of community leaders the issue that recruitment and retention of professionals is not limited to nursing.

iii) Return to service agreement for employer sponsorship of formal education.

Nurses in many small rural or northern acute care facilities expressed concern regarding the lack of an on-call nurse for back up in emergencies and client transfers.

On call for small rural/northern facilities

Nurses in many small rural or northern acute care facilities expressed concern regarding the lack of an on-call nurse for back-up in emergencies and client transfers. This need was intensified in the presence of newer, less experienced staff. The frequency with which this nurse may be needed would vary. However, the stress related to the isolation and demands of the individual nurse while at work, and the time that would be required from that same nurse to find additional nursing staff was a significant source of stress.

Many nurses utilized an informal and unofficial system of back-up support, counting on long-standing personal relationships with peers to bring in additional nurses in times of significant need. Many nurses work extra hours to assist their colleagues on a phone call from these nurses or simply upon hearing the sound of an ambulance, a detriment to family or personal time and health. These nurses voiced significant concern over what will happen upon their retirement when those long-standing relationships no longer exist. Nurses recommended that Manitoba Health provide the RHAs with additional funds for on-call pay and on-call supports, such as pagers.

Recommendations:

i) Discussion at facility/regional level re: the needs and requirements for on-call systems in small/rural northern facilities.

ii) Additional funding is provided to the RHAs to support an on-call system.

EFT positions in rural and northern nursing

There was a consensus in rural nursing areas that 0.8 nursing positions are required to attract new nurses to a position. The majority of nurses in rural areas indicated that their presence in the community was related to family commitments, farming or other small business practices. The viability of businesses in the rural environment has led to a decline in the source of new nurses who would arrive and settle in the community. Those rural settings closer to the larger urban areas have the added competition of the greater number of high EFT positions within commuting distance.

Recommendations:

i) The RHAs explore with nurses the potential for higher EFT rotations.

ii) Explore the need for full-time float positions.

Working Conditions

"Nursing leader" specific to unit or practice setting

A nurse in a position of authority and leadership on the unit or practice setting with day-to-day unit or practice responsibilities was seen as a necessary adjunct to the current role of nurse managers. The inclusion of such a nurse in a position of leadership was identified as arising from a number of issues:

- A "nurse leader" would assist with/meet the need for day-to-day continuity of care and care planning; consistent communication to family and health professionals; mentoring of staff (particularly of new staff); continuity of ward planning, such as with equipment; clinical guidance; and support, resource, leadership and supervision to front-line nurses. "Families have no consistent person to go to."
- Nurses indicated that "staff have no one to go to" for direction or support with problem solving.
- The elimination of the "head nurse" was felt to lead to in-fighting between some units and nurses. Nurses and units feel left to themselves to advocate for scarce resources and staff, and there are perceived inequities of workload and quality of care provided between units/programs and/or nurses.
- A nursing leader could assist in bringing current practice issues to/from nurses. "Head nurses used to be there to set the standard, and especially with the new practitioner someone needs to be there to set the standard – this has gone by the way side."
- Staff nurses acknowledge their ability to perform many of the functions that were previously the responsibility of a "head nurse," however they reported a lack of mentorship or training to adequately and comfortably assume those roles.
- Staff nurses who assume daily charge responsibilities on a rotational basis were seen to perform the charge role differently, escalating the lack of continuity and co-ordination in areas such as client care, discharge, supplies and unit/program priorities.
- The lack of a consistent charge person on in-patient units was found by community practitioners to impact on the ability to provide client continuity upon client referral and transition into community health care.

This "nursing leader" position would not replace or supplant the autonomy or holistic practice of nurses, but enhance their autonomy and assessment skills. The lack of a unit-based nursing leader or resource was considered to be "a missing piece."

Community nurses stated that their autonomy was key to worklife satisfaction, however they also indicated the conflict they felt in needing the support of a next line supervisor, while recognizing that the workload and demands of that individual appeared to exceed their own.

The institution of a "nursing leader" would also expand opportunities for career advancement and growth. The first-line manager was seen to have an increased and unmanageable range of responsibilities. "The greater the workload of the program managers, the higher the stress of the unit – no matter how good she is." The large number of vacant manager positions in one RHA was attributed by staff to the unfeasible professional and personal demands of the manager position. The "job expectations are designed for burn-out." These perceptions appeared to be at odds with the perception that management layers are "top-heavy."

The wide range of responsibilities of managers limits their access to information and support in their environment; the opportunity to observe and recognize staff nursing skill and expertise; and the ability to provide opportunities for staff to grow and achieve. Nurse managers are unable to be as visible as both they and staff would prefer, another element recognized as of considerable importance in MAGNET hospital research. Such opportunities were an important source of satisfaction for managers. Without a consistent and available nursing leader, nurses are not receiving feedback about their abilities.

- ***This "nursing leader" position would not replace or supplant the autonomy or holistic practice of nurses, but enhance their autonomy and assessment skills.***

- ***Community nurses stated that their autonomy was key to worklife satisfaction.***

- ***The institution of a "nursing leader" would also expand opportunities for career advancement and growth.***

• *"Performance appraisals are not always liked but they're not happening and this is a way of providing positive and constructive feedback."*

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Staff nurses also voiced recognition of the limited discretionary power of their next closest supervisor to act autonomously on behalf of their staff, acknowledging the frustration this places on staff, and the stress this may place on that manager. As recognized by the submission of KCC, "Many nurses in leadership positions are hindered by the bureaucratic systems in place that do not regard nurses as professionals." A reinstitution of the position of Head Nurse was also among the recommendations submitted to the Task Force by the MNU. The submission by the WRHA supported the need for available managers recommending: "ensure the availability and constant presence of managers who play a crucial role in framing the worklife for nurses. The managers' role includes the very important aspects of mentoring, coaching, and supporting personally and professionally, as well as the provision of clinical leadership."

Similar concerns were related to the absence of evening/night supervisors in greater than 50-bed hospitals. Among other roles, shift supervisors were viewed as the coordinators of patient/resident care and staffing, and provided guidance and problem solving.

Despite the differences of opinion between some nurse managers and staff, each generally demonstrated mutual recognition and respect for each other's roles and responsibilities.

Recommendations:

i) The RHAs work with staff nurses to identify the requirement for additional site-based nursing leaders, including evening/night/weekend nursing supervisors.

ii) Implementation be supported by Manitoba Health financially and otherwise.

Public utilization of the Emergency room

• *The emergency room (ER) in many rural facilities appeared to be utilized as a physician clinic, particularly on weekends and evenings, or in locations with a physician shortage.*

The emergency room (ER) in many rural facilities appeared to be utilized as a physician clinic, particularly on weekends and evenings, or in locations with a physician shortage. Many nurses felt that physicians may use the ER as a physician office, with the nurses expected to provide a clinic nurse role. Nurses in rural/northern facilities have to integrate this unplanned workload into their concurrent in-patient and truly emergent responsibilities, to the detriment of the quality of care of in-patients. An additional stressor for the RN in many rural facilities, during an emergency, is finding access for the client in a Winnipeg hospital.

Recommendations:

i) The RHAs review the role of emergency rooms and the use of ER nurses with the goal of implementing strategies to reduce inappropriate use of the ER.

ii) Provide public education regarding appropriate use of emergency facilities. A model may be found in the recent BC Health Guide handbook (http://www.hlth.gov.bc.ca/cpa/newsrel/2001/087.html)

iii) A central bed registry is developed for emergent rural referrals to tertiary care centres for after hours/weekends/holidays.

Equipment

"The lack of equipment and supplies is a time waster and adds to frustration." Attempting to provide care with inadequate and/or nonfunctioning equipment is seen as a waste of valuable nursing time. Time is unnecessarily spent looking for scarce equipment, or trying to work with that which is inadequate due to disrepair. Similarly, nurses in some regions reported a lack of basic linen and supplies for procedures. Inadequate chairs and desks for nurses were translated into a perception of devaluing. The submission by the MNU reinforced the frustration of nurses working with "antiquated or faulty equipment." Nurses working in provincial correctional facilities similarly reported a deficiency in medical/nursing and office equipment.

Question # 20 on the survey asked participants for suggestions that would make their workplace more supportive. Approximately seven percent of the respondents indicated a need to improve equipment and technology.

Recommendation:

i) Manitoba Health provides adequate capital and operating funds to each RHA for timely maintenance and updating of equipment.

Provincial Employee Assistance Program (EAP) and Critical Incident Stress Management Program (CISMP)

Employment assistance programs are not available on a provincial basis. This is in significant contrast to the acknowledged increased stress of health care staff. A successful EAP program has been accepted and proven to reduce absenteeism and sick time. EAP programs were identified as needing to be off-site in order to maintain confidentiality, particularly in rural areas, as the EAP provider may know the individual experiencing the need or crisis. Community supports through community mental health may be available but do not appear to be well known, and may lack the anonymity for staff to comfortably access. Further, the resources of community mental health practitioners are themselves strained.

Keewatin Community College also recognized the need for "care for the caregiver" in their submission. The 1996 survey of nurses (n = 300) by nurses at the Manitoba Nurses Union annual general meeting found that 42% of those surveyed "said that they did not think that they are able to cope well." Additionally, 95% of those nurses surveyed "stated that they see the mental and physical health of their coworkers being harmed by occupational stress."

In one RHA, 24 hour Critical Incident Stress Management Teams have recently been implemented at three large in-patient facilities. Nursing staff assumed these roles and responsibilities within existing workloads. The role of the team includes staff education, and establishing and mentoring of peer debriefers. Funding is limited and is used primarily for clerical support and evaluation. The majority of health care providers in this region do not have formal access to a CISMP.

Question # 20 on the survey asked participants for suggestions that would make their workplace more supportive. Approximately 13 percent of the respondents indicated a need for EAP.

A few RHAs have supported workshops that address worklife issues. The Westman Staff Development Interest Group presented a workshop by Cathy Fenwick, MA, "Workscapes: Keeping Spirit Alive at Work". A free workshop to staff in eight RHAs was provided by The Alliance for the Prevention of Chronic Disease Inc. Topics included "Conflict Resolution and Negotiation Skills" and "Leadership: Building an empowered and collaborative team". The St. Boniface General Hospital in Winnipeg developed or sponsored a number of workshops such as "Exploring Patient Abuse," "Coping with Anger in a Changing Workplace," "Coping with the Stress of Negativity in the Workplace" and "Tools for Success in Working with Others."

Davis and Thorburn (1999) describe the development a multi-sectoral and multifaceted "Nurses Quality of Worklife Team" by the Health Care Corporation of St. John's in response to health care mergers and changes in management structure. The core of the program was a "Nursing Peer Support Program" that was linked with an EAP. A preliminary evaluation indicated the majority of respondents were aware of the program and that the majority of Nursing Peer Support People had been approached for assistance.

The submission by the MNU included a variety of self-reports of increased stress in work settings where unresolved issues were referred to an Independent Assessment Committee. Self-reported signs included disrupted sleeping, depression, an increase in the number of stress leaves and an increased rate of absenteeism related to increased sick time. The WRHA recommended a system-wide EAP in their submission.

Recommendations:

i) Implementation of a province-wide and accessible EAP, with complete funding by Manitoba Health.

ii) Implementation of a province-wide and accessible Critical Incident Stress Management Program (CISMP) with complete funding by Manitoba Health.

- ***Approximately seven percent of the respondents indicated a need to improve equipment and technology.***

- ***Employment assistance programs are not available on a provincial basis.***

- ***Self-reported signs included disrupted sleeping, depression, an increase in the number of stress leaves and an increased rate of absenteeism related to increased sick time.***

Staff security and safety

• *Nurses in facilities and in the community expressed concerns about safety and security.*

Nurses in facilities and in the community expressed concerns about safety and security. Staff, clients and physical assets are at risk. The isolation and limited numbers of nurses in small rural/northern facilities and in the community further heightened this fear and anxiety.

Restructuring within the RCMP has reduced the availability of RCMP to provide a rapid response to actual or potential risk situations. For those communities with limited RCMP support, a community infrastructure to address security issues may be unavailable. While many facilities lock their doors at night, safety concerns continue related to: lack of visibility by video camera or window of persons wanting to come in; the challenge in assessing the health condition and safety of the person at the door and subsequent difficulty refusing care to someone who may be in need; the reliance on nurses to lock the doors at night; easy access through windows and doors in older facilities; and the lack of security personnel. Options such as a panic button appear to provide reassurance, however such equipment would need to be carried by all personnel and have a local response to alarms. One RHA reported cross-training positions such as security/aides, and housekeeper/security to enhance the level of security for both the internal and external facility environments. Other sites have worked with EMS and/or fire departments to provide a rapid response.

• *Nurses who work in the community often work alone, traveling long distances or to isolated areas.*

Nurses who work in the community setting often work alone, travel long distances to see clients and work in isolated areas. Unique concerns relate to communication and transportation:

- While some staff are provided with pagers, this allows only one-way contact to the nurse, not from the nurse. Communication via cells phones is optimal for safety, but limited due to "dead spaces" in rural Manitoba. Should nurses require assistance for personal security or safety, they have no means of outside contact.
- Vehicles are not consistently provided for staff use. Most vehicles provided are not appropriate for the road and weather conditions of Manitoba. It was expressed by many nurses that the compensation paid for the utilization of personal vehicles is insufficient to cover the "wear and tear" on their vehicle.
- Nurses who travel on waterways and air have additional concerns related to safety standards.

The submission from First Nations and Inuit Health Branch (2000) included a copy of a Threat and Risk assessment for each nursing station. The five most vulnerable areas were as follows: 1) security and safety of employees in the workplace and accommodations; 2) infrastructure and building design and maintenance; 3) security and maintenance of assets; 4) general health and safety of employees; and 5) response to threats, emergencies and safety/security concerns.

Recommendations:

i) Encourage the Manitoba Government to lobby the telecommunications industry to expand cellular phone coverage within rural and northern Manitoba.

ii) Winter survival kits are supplied for nurses in jobs requiring travel in rural/northern areas.

iii) A means for contacting persons in an emergency while on work-related travel is provided, such as a cell phone.

iv) Development of regional criteria for vehicle assignment taking into consideration personal and vehicle safety, and environment/geography.

v) Internal and external security systems, including on-site security personnel, volunteers or cross-trained personnel as applicable, be reviewed, and criteria and standards set, implemented and evaluated by the Workplace Health and Safety committees.

vi) Workplace Health and Safety Committees investigate the availability of parking as it relates to a safe environment

Availability of food services for clients and staff

The availability of food services in facilities varied. Food service hours are often restricted. In smaller facilities food services may be open only around client meal times.

Such restrictions offer another challenge to staff as they coordinate their many roles and responsibilities so that they can fit their meals to specific client-related meal times. Full cafeteria services were recommended in the submission by KCC and the MNU. Supper meal times of approximately 1645 hours were identified as too early for in-patients/residents. During evenings and weekends, food service in facilities may be restricted to vending machines or nothing. Vending machines were viewed as providing limited options and quickly emptied by family and clients, leaving little for staff. Clients admitted late to a facility may be dependent upon those same vending machines or nurses to provide snacks, regardless of medical diet needs. The limited options in some facilities were viewed as another source of devaluing.

Recommendations:

i) The RHAs explore the expansion of food services for staff, clients and visitors, including appropriate meal times for clients.

Day care

The need for child day care varied. Most nurses felt the increasing age of the nursing workforce as the reason why this issue was not raised as extensively as anticipated by the Task Force. In general, day care was seen as providing the most benefit for casual staff or those who provide sick relief and are called in to work at the last minute. The optimal day care to meet these needs was felt to be available 24 hours, without restriction on minimum age. Other unique needs for day care included "before and after" day shift and support for Home Care workers at their busiest times, such as supper and bedtime. Selected towns with younger families, supported by industry, demonstrated the significant difficulties associated with finding qualified 24-hour day care for shift workers with irregular hours. The need for day care was recognized by the KCC, WRHA and the MNU in their submissions.

Question #16 on the survey asked participants which of the following services would assist them in their own care giving role: child day care; low-cost meals to take home; improved transportation to and from work; respite care; and adult day care.

Of the 1,160 respondents who indicated that there are services that would assist in their caregiving role, 33.5% checked child day care. A further 9.7% of the respondents who agreed that there were not services that would assist in their caregiving role also checked day care. Additional references were made to accessibility issues in childcare, such as 24-hour childcare, on-site childcare and drop-in access/after school programs for children.

Recommendation:

i) Explore the need for additional subsidized day care spots in collaboration with Manitoba Family Services and Housing.

Pilot project:

i) The Pas may be a potential pilot project site for exploring 24-hour day care.

Education

Current, accessible, affordable continuing education

In all regions, nurses stated that there was limited opportunity for ongoing professional development and growth. Participation in continuing education was felt to be key to instilling, maintaining and fostering professional satisfaction, commitment, confidence, empowerment and subsequently, quality of care, the health of nurses and retention. "With knowledge, comes power" in order to assist in providing client care. "A solid knowledge base will provide us with the foundation to be strong."

Question # 19 on the survey asked participants to choose from a selection of items the activities that they "feel would increase (their) job satisfaction and/or reduce personal stress." Fifty-two percent of the respondents included the selection of "on-site education resources" in their response. A further 12.5% voiced the need for support related to continuing education as further suggestions (see appendix J for further analysis).

Funding initiatives for continuing education by the Recruitment and Retention Fund and the collective agreement with MNU were described as a "great start" but limited in their funding, access and awareness. The

• ***Other unique needs for day care included "before and after" day shift and support for Home Care workers at their busiest times, such as supper and bedtime.***

• ***Additional references were made to accessibility issues in childcare, such as 24-hour childcare, on-site childcare and drop-in access/after school programs for children.***

collective agreement with the MNU indicates that "the nurse shall be granted, upon written request, funding up to a maximum of $200 annually to attend approved workshops, courses, and other programs that are relevant to the nurse's current area of practice." Reimbursement of such funds occurs upon satisfactory completion of the program, a financial hardship for some nurses. Funding is insufficient to cover related costs such as travel and salary. Many nurses further disagreed with the need for approval of the educational program by the RHA.

• ***A short-term investment in continuing education would bring long-term benefits for the employer.***

The Recruitment and Retention Fund has allocated $3 million to the RHAs to support the continuing education of Registered Nurses, Licensed Practical Nurses, and Registered Psychiatric Nurses who are direct caregivers or first-level managers. Funding for continuing education is for short-term strategies (up to 14 days) and activities that enhance the nurse's role in the work environment. Each RHA has or will receive an initial 25% of allocated funding once regional working committees comprised of management, MNU representatives and front-line nurses have been established and approved by the Nurses Recruitment and Retention Fund Committee; and once an initial report outlining a description of activities, summary of expenses and outcomes for use of the continuing education funds has been submitted. The majority of funding was provided to all but one RHA between July and October 2000. Additional funding will be provided to RHAs once the Nurses Recruitment and Retention Fund committee is provided with quarterly reports outlining how the initial funding was utilized. Regional committees are responsible for the utilization of funds within their region. The availability of these funds did not yet appear to be well known by nurses during the Task Force regional meetings.

• ***The majority of the submissions identified the need for further training in skills such as leadership, assertiveness and stress management, to assist nurses with the complex demands of the health care environment.***

A short-term investment in continuing education would bring long-term benefits for the employer. The nurses in the general meetings encouraged support for continuing education in the following ways:

- Payment for tuition upon registration for continuing education;
- Paid time off from work to attend continuing education;
- Salary replacement when attending education on days off;
- Staff replacement scheduling by the employer;
- Support leave of absence requests to address formal educational;
- Courses integral to provision of safe and competent care should be supplied at no cost to the nurse, e.g., ACLS for emergency room nurses

Accessible education meant different things in different regions:

- Regional preferences ranged from access to current and relevant videos, print resources or distance education to on-site courses or in-services. Selected rural sites have the opportunity to use Tele-health technology, available largely due to specific program linkages with the Faculty of Medicine at the University of Manitoba.
- Sites identified unique preferences of obtaining ongoing professional education, such as the Internet, books, in-person educators, and in-services. Educational opportunities off site were valued for the opportunity for networking, particularly among geographically or professionally isolated nurses.
- Issues related to the accessibility to education included access to formal educational programs at the college or university level via complete distance education or local on-site courses.

The importance of re-education for basic skills such as charting, dressing changes and infection control was identified in some sites due to the long-standing inattention to such subject matter. The majority of the submissions identified the need for further training in skills such as leadership, assertiveness and stress management, to assist nurses with the complex demands of the health care environment.

In their submission, Keewatin Community College (KCC) supported the need for, and benefit of distance continuing education in their submission. The joint benefits of continuing education to the employer and nurse was reinforced in the following statement by First Nations and Inuit Health

Branch: "One of the Manitoba Region's best recruitment tools is the Primary Care Skills course that is offered by the University of Manitoba." The Faculty of Nursing at the University of Manitoba (U of M) indicated that it has entered into a partnership with the Continuing Education Division at the U of M to offer "Professional Continuing Education for Registered Nurses." Non-credit workshops will be offered off-campus and through interactive video based on learning needs assessments from the RHAs. One of the first initiatives is an eight-week health assessment course provided locally with the Interlake Regional Health Authority.

Participation in continuing education was not seen by nurses to be factored into job benefits or the hiring process. The limited career laddering in nursing further restricts the opportunity for nurses to gain formal recognition for increasing education and expertise, further limiting the opportunity for nurses to grow and develop within the organization.

Every nursing setting reported an increased patient acuity, increased workload and heightened use of treatment modalities and technology. Such changes did not by and large appear supported by an increase in staffing or facility-wide in-services or education. This disparity was directly related to the lack of educational resources. Staff commonly related the institution of new technology in the practice setting without receiving any prior education. In general, policy and procedure manuals were felt to be out of date, representing deterioration in standards. "Nurses used to be high achieving; doing transfer of functions – nothing now, we have gone backwards."

The provision and role of in-service educators varied:

- Some RHAs have recently initiated regional or geographically-based positions for continuing education. Those facilities or agencies accustomed to on-site educators perceive a loss in education resources, while those who did not have a previous position perceived a gain.
- Many current site or local in-service providers appear inundated with additional responsibilities, regretting having the time only to provide basic and/or mandatory education such as Basic Cardiac Life Support Programs (BCLS). Staff educators may be asked to assume, within the same time commitments, additional roles such as infection control and accreditation.
- Health care providers closer to urban centers appeared to have a greater connection with those centers as an additional resource for new information on care needs and procedures, for example, when clients were transferred back to the rural setting. This link, support and advance knowledge of transfer was not found to be consistent, but seen to be essential.

The Education Services of the South Westman Regional Health Authority shared with the Task Force their regional staff needs assessment from which planning and prioritizing of regional continuing education programs is to be based. Thirty-five percent of RHA staff participated in focus groups at regional sites. This comprehensive and in-depth needs approach also included communication and feedback to staff via a regional newsletter dedicated to continuing education, *Education Connection*. The submission by the WRHA includes a recommendation to provide support – financial and time – for continuing education opportunities, which encourage "the retention of the aging, mature nurse."

Recommendations:

i) Continuing education should be a priority in the provision of additional funding and resource allocation to the RHAs:

   a) Updated and on-line/computerized regional policy and procedure manuals, with financial support from Manitoba Health for capital and human resource costs.

   b) Manitoba Health explore with RHAM the potential for, and fund as necessary, the placement of standardized nursing procedures on a Web site to support immediate province-wide accessibility to current client care procedures.

   c) Ongoing financial support for continuing education is provided

• The limited career laddering in nursing further restricts the opportunity for nurses to gain formal recognition for increasing education and expertise, further limiting the opportunity for nurses to grow and develop within the organization.

• Every nursing setting reported an increased patient acuity, increased workload and heightened use of treatment modalities and technology.

• Continuing education should be a priority in the provision of additional funding and resource allocation to the RHAs.

annually through the Provincial Recruitment and Retention Fund.

ii) Manitoba Health explore ongoing mechanisms for funding educational programs beyond 14 days such as the Operating Room Course and Intensive Care Courses.

iii) Base budgets appropriately reflect continuing educational needs, including sufficient funding for regional or facility programs, including financial, human and educational resources.

iv) Academic educators enhance the content and delivery of distance education both within undergraduate, graduate and continuing education programs.

v) RHAs develop a formal interview process so that participation in continuing education programs can be recognized and appropriately factored into the awarding of posted positions.

Pilot project:

i) Demonstration project for the development of updated and on-line/computerized regional policy and procedure manuals in Marquette RHA. Marquette RHA currently has network capabilities. Project to be fully funded by Manitoba Health for dedicated resources. Evaluation of costs, resources and outcomes after one year for possible application in other RHAs.

Educational resources

Resources for client and staff education were markedly out of date in many sites. An example of outdated staff resources is the availability of the Compendium of Pharmaceuticals and Specialties (CPS) in public health or home care, some as old as 1989. Computers and the Internet are largely unavailable for nurses who feel unable to keep pace with the information obtained by clients who access health education on the Internet, and those clients' subsequent queries.

Printed client education materials are old and outdated. They are found and photocopied from a variety of places "any place we can." For-profit companies distribute some printed information as part of their marketing strategy. Community nurses repeatedly expressed regret over the loss of the centralized mechanism in Manitoba Health for the development and distribution of educational materials. An example of the public distribution of provincial health education materials via the Internet can be found within the Web site of "Healthy Newfoundland and Labrador," a joint project between federal and provincial health agencies at: http://healthy.nf.ca/pamphlets/index.htm.

Policy and procedure manuals were seen to be similarly outdated. Although the diversity of facilities and agencies were felt to challenge common procedures, policies or standards, a centralized resource program could provide a template for locally appropriate modifications.

Recommendations:

i) Manitoba Health, in consultation with RHAM, develop and maintain a centralized provincial pool of current client education materials on-line.

ii) Nurses have access to computers with on-line capability at close proximity to nursing activity with corresponding education re: computer utilization.

iii) Manitoba Health identifies and makes available key health sites on the Internet that provide reputable and valid health information.

iv) Manitoba Health support implementation and maintenance costs of the above recommendations.

Community Health

Facilities for community health

Community health offices are often sites of client contact and intervention. The space available to rural community health staff traveling to local areas was perceived to be provided to the best of the ability of the RHAs, however such spaces in all RHAs often demonstrated a number of limitations. These include lack of privacy and thus confidentiality when meeting clients, lack of space, lack of a phone, inadequate or poor furniture, lack of technology and inability to store resources.

• Resources for client and staff education were markedly out of date in many sites.

• Community nurses repeatedly expressed regret over the loss of the centralized mechanism in Manitoba Health for the development and distribution of educational materials.

In one RHA, permanent community health staff revealed working in "condemned" buildings, with environmental concerns expressed such as poor air quality, unacceptable levels of lead in the water, asbestos in the walls, and leaking water. In addition to the impact on staff health and the barriers to work quality, the work environment in which clients are met was viewed as unprofessional and embarrassing, directly impacting the ability to deliver quality care.

The above environmental and space deficiencies have been identified as long-standing problems of 10 years or more.

Recommendations:

i) Review of all community health facilities by the RHAs.

ii) Secure adequate, appropriate space for community health staff with ergonomically appropriate design in consultation with staff nurses.

iii) Due to the safety issues surrounding some environments, capital monies must be released outside of the capital budget process.

iv) Other requirements may be addressed in the capital budget process for 2003-2004 (given budgeting cycle).

Additional provincial community health programs

New initiatives for community health, viewed as excellent programs, have been introduced with limited and/or uncoordinated resources, operational funds, orientation, training, or implementation strategies. Such programming is thus viewed as just "one more demand, one more piece of work, more red tape." The pace of introduction of new programs was encouraged to be slowed, allowing for time to "catch up" and analyze/evaluate the system. The addition of programs has further challenged the ability of community health staff to provide basic care/programs without vacation replacement. Manitoba Health and RHA staff and management have differing opinions about the process of implementing community programs.

Recommendations:

i) The introduction of new community health programs is slowed to allow for time to "catch up."

ii) The RHAs are included in the preliminary planning for community programs by Manitoba Health, allowing for coordination of resources and consideration of process.

iii) Manitoba Health revisits the establishment of a Public Health Nursing Branch.

iv) New community programs must be introduced with additional and appropriate resources, supports and staff as part of a long-term provincial strategic plan.

• ***The addition of programs has further challenged the ability of community health staff to provide basic care/programs without vacation replacement.***

Home Care

Most home care offices are staffed only with casual positions. Nurses, who might otherwise choose to work only in home care, have to work in permanent full-time positions elsewhere to make up their desired EFT. Alternatively, nurses who work full-time in other programs or facilities would provide support to their local community by providing home care as indicated and available. However, since regionalization and subsequent amalgamation of unions and facilities, nurses working an equivalent of greater than full-time within the region, are now considered to be working overtime. This restricts their availability to work what may now be "overtime" within home care.

Autonomy and 1:1 client care provide high job satisfaction for home care nurses. The lack of permanent positions significantly limits staffing availability and the ability of the Home Care Program to take on long-term clients. The lack of guaranteed hours for nurses also restricts the opportunity of nurses to coordinate and schedule family or personal needs, and work. In some RHAs, regular staffing may assist with increased utilization of home care, however the large territory and sparse population in some areas would continue to challenge a quick response to needs or long-term clients.

• ***Autonomy and 1:1 client care provide high job satisfaction for home care nurses.***

While some regions are beginning to provide guaranteed hours for direct service nurses, this does not include guaranteed EFT. This is not being expanded to other home care staff.

Recommendations:

i) The RHAs, Manitoba Health and the union work towards permanent EFTs in Home Care.

ii) Explore the expansion of Home Care programming in the rural areas, such as Home Intravenous Program.

Valuing

Communication

- ***"Lack of communication leads to distrust and resentment."***

A variety of methods of communication were in place for communication to and from the RHA office. Methods of communication included newsletters, memos, unit communication books, regional meetings, staff meetings and group e-mail. Regardless of the variety of communication strategies, there was a general desire for more "meaningful" and "relevant" information, with open feedback from suggestions and questions from staff. Perceived lack of information, regardless of accuracy, was seen as leading to mistrust and rumour. "Lack of communication leads to distrust and resentment." The means and content of communication preferred by staff nurses varied widely.

- ***Nurses consistently desired the ability to have input and wished for feedback regarding their suggestions, local discussions, ideas or input into health care planning. The communication lines to management appeared by staff nurses to be blocked, further enhancing the perception of their lack of value and disempowerment.***

Nurses consistently desired the ability to have input and wished for feedback regarding their suggestions, local discussions, ideas or input into health care planning. The communication lines to management appeared by staff nurses to be blocked, further enhancing the perception of their lack of value and disempowerment. Of those next line supervisors whom staff expressed were able to provide communication and feedback to the staff nurses, delays in communication and feedback appeared to occur above that level. Blocks to communication by front-line managers were often attributed by staff nurses to their lack of power and overloaded responsibilities. Managers commended were those who were found to be very "open" and "asks and listens"; and most importantly, provided feedback regarding suggestions.

It was recognized that most managers hold the same ideals, but are limited in the ability to enact these roles due to their broad span of responsibility or they are restricted in what changes can be made. The lack of accessibility to current nursing job postings was identified as another source of inadequate communication.

The roles and responsibilities of the RHA and Manitoba Health also appeared unclear. The RHA was often attributed as having complete responsibility for decision-making including funding, programming, staffing guidelines and construction and design of new facilities, regardless of their actual authority. Enhanced communication to staff pertaining to the role and decision-making of Manitoba Health and the RHA would lead to a more comprehensive understanding of the rationale for decisions made and the drivers behind decision-making.

Submissions from other nursing groups such as Corrections and First Nations and Inuit Health Branch indicated utilizing meetings as the primary means of ongoing communication.

Recommendations:

i) Incorporate local/regional solutions to effective communication between staff and all levels of management.

ii) Enhance communication to staff pertaining to the role, decision-making process and accountability of Manitoba Health and the RHAs.

iii) Nurses are formally included in decision-making and consultative roles within the provincial and national governments.

iv) Organizational structures support direct input by nurses in decision-making that impacts on their work, with reimbursement for time spent outside of work hours supported financially by Manitoba Health.

v) Explore the feasibility of developing a mechanism to publicly identify current posted nursing positions in Manitoba. This could possibly be a responsibility of the Provincial Recruitment and Retention Committee in collaboration with the Provincial Human Resources Network

Value and recognition

Nurses identified both informal and formal sources of recognition and valuing. Formal sources such as long-term recognition and staff barbecues varied in their reception by nurses. These measures were variously

perceived as a "start," "appreciated" but also as automatic, as lip service and misdirected funds. Devaluing nurses occurs at many levels and in many venues, such as the employee-employer relationship, public and government.

Nurses most appreciate informal and personal sources of valuing such as verbal praise, including "thank you." The frequency of praise was out of proportion to "always hearing when you do something wrong." Recognition of value was not necessarily required to be financial. While the benefit of financial rewards was not discounted, it appeared of less importance on an individual level until the salary ceiling was reached. "Money is not necessarily the answer." "Small things make a difference." Some managers use their own money to provide small items of recognition, valued by staff. Most managers do not have discretionary funds with which to provide personal incentives, despite the recognition that staff are "bending over backwards" "going above and beyond." There were differing views of the need for and/or what a staff wellness program could offer, such as on-site vs. off-site fitness facilities/ programs, nutritionist, or massage therapist.

The use of formal recognition of individual achievement by a nurse, while effective for that individual, would be at risk of inadvertently omitting those whose achievements did not come to the attention of the manager.

Staff empowerment and control has been strongly linked to commitment and staff satisfaction. Working conditions are limiting nurses' autonomy and authority to act on their knowledge and clinical judgment.

The small numbers of nurses working in sub-specialties such as Provincial Corrections is perceived to further hinder their ability to have their needs acknowledged. This concern ranges from tangible issues such as staffing levels, need for higher full-time and permanent positions and needs for clerical support, to professional issues such as professional recognition and partnerships with the larger health care community or RHA, peer support and support within the partnered non-health care community.

Recommendations:

i) Consideration be given to paid coffee/meals for staff on overtime or short notice shifts; or on statutory holidays.

ii) All new capital projects include staff lounges, which would be dedicated to staff use only.

iii) Petty cash from the Provincial Recruitment and Retention fund is allocated to each region for discretionary use, for the purpose of acknowledging nursing staff.

iv) Each RHA investigate the opportunity for staff wellness initiatives based on staff feedback.

Image of the profession of nursing and of the health care system

Many nurses expressed an increase in verbal abuse from clients and families. This was attributed by nurses to increased public expectations for health care; negative advertising and media coverage by and of nurses; lack of public understanding of the implications of a shortage of nurses; negative publicity regarding the state of health care; and the resultant perception by clients of their need to assertively advocate for themselves in order to receive health care. As the front-line care provider, nurses felt that they were most often the recipient of abuse and anger, regardless of the circumstances or the ability of the nurses to change those circumstances.

The previous low levels of students entering the nursing profession were attributed by many to the negative image of nursing and to the expansion of opportunities for women and men outside of nursing. The current increase in nursing students is feared to be just another example of the cyclical nature of nursing employment unless fundamental changes occur to the image and valuing of nursing by society.

The perception of nursing as a valued profession was seen to be decreasing. Nurses are impacted by the crisis of confidence in health care. As reinforced by KCC, the public at large continues to view nursing predominantly as a task-based occupational group rather than a profession with a

- ***Nurses most appreciate informal and personal sources of valuing such as verbal praise, including "thank you." The frequency of praise was out of proportion to "always hearing when you do something wrong."***

- ***"Money is not necessarily the answer."***

- ***Working conditions are limiting nurses' autonomy and authority to act on their knowledge and clinical judgment.***

- ***As the front-line care provider, nurses felt that they were most often the recipient of abuse and anger, regardless of the circumstances or the ability of the nurses to change those circumstances.***

specialized body of knowledge and practice. Concurrently many nurses felt unsupported by management in their concerns regarding verbal abuse. Such negative publicity and media coverage about health care and nursing further dissuades persons from entering the profession. Nurses are also seen to be feeding on the negativism, disempowering themselves, escalating the overall stress.

Recommendations:

i) The Provincial Nursing Resource Task Force and/or the Nurses Recruitment and Retention Fund Committee be approached to develop a media/marketing campaign:

a) that acknowledges the role of nursing;

b) that provides education regarding the impact of the nursing shortage;

c) that addresses nurse abuse and its effects;

d) that enhances public awareness about the responsibilities and decision-making inherent in nursing practice.

- ***Such negative publicity and media coverage about health care and nursing further dissuades persons from entering the profession. Nurses are also seen to be feeding on the negativism, disempowering themselves, escalating the overall stress.***

Recognize and utilize nurses to their fullest potential and autonomy

Nurses do not feel that the work environment supports the true professional practice of nurses. Nurses' inability to practice according to their professional standards and values was a major source of dissatisfaction. Nurses felt unable to make appropriate decisions based on their expertise and professional judgment, or to gain control over the implementation and outcome of these decisions. The importance of autonomy in clinical practice and of an environment that supports professional practice to nursing satisfaction, recruitment and retention has further been reinforced by the research on MAGNET hospitals. Participation on committees and decision-making bodies within and outside of the work unit is another mechanism to developing an increased sense of control and input, and sense of organizational autonomy. This contribution is frequently not supported by time back and/or salary, or a realistic sense of input. In a 1996 survey of occupational stress using the Job Content Questionnaire (n = 300) at an Annual General Meeting, the Manitoba Nurses Union reported that 52% of nurses "said that they have a lot of say in their work." The MNU included a recommendation that nurses receive support to sit on hospital committees within their submission.

- ***Nurses do not feel that the work environment supports the true professional practice of nurses. Nurses' inability to practice according to their professional standards and values was a major source of dissatisfaction.***

Nurses expressed the lack of control over the care they were able to provide in their day-to-day practice. They are unable to act on their knowledge and judgment. Nurses feel unable to accomplish their work, indicating less opportunity to exercise nursing professional practice and expertise, judgment, and to influence the client, family or organization. "We need to move outside of the medical model and advance within nursing." "We seem to break out in little bits only."

- ***Nurses expressed the lack of control over the care they were able to provide in their day-to-day practice.***

Nurses in the general meetings relayed their perception that the delay in passing of the Registered Nurses Act was a further sign of devaluing nurses. The delay in enactment is also seen as denying the opportunity for nurses to provide advanced care to their full scope, as reflected in the changes in the Act. The RN Act was perceived as "being held beyond our control," and as another example of how "control of practice is out of our hands." The submission by the WRHA included a recommendation to provide and support models for nursing autonomous practice.

Recommendation:

i) Nurses are provided with specific rationale regarding the delay in passing of the RN act.

ii) Utilization of nursing roles and skill within regions to their fullest potential reflective of current educational curriculums.

iii) Participation in committees or professional activities be recognized, and be a contributing factor when looking for opportunities for career advancement.

Differential attention to retention and recruitment

"Focus first on those who you have" was a widespread theme among practicing nurses in Manitoba. Nurses indicated that they are just "hanging on." Attention to the work

satisfaction and working conditions of nurses in the system was considered imperative to retention. The submission by the Manitoba Nurses Union further reinforced this need: "We must ensure that those nurses who have dedicated years to caring for our sick and our elderly under extremely stressful conditions are supported in their decision to continue to provide nursing care at the bedside and in the community." A further study by MNU in 1998 reported that 55% of nurses surveyed in Manitoba indicated, "that if given the opportunity they would pursue another career and leave nursing" and that 69% of all nurses surveyed "would not recommend nursing as a good career choice."

The implementation of financial incentives such as signing bonuses as means to attract new staff is increasingly offered as part of the recruitment package. (This was seen as one method of recruitment, in particular for those that supported repayment of student debt.) However, the absences of similar incentives for staff that choose to stay have the potential to create division between new nurses and those already working. Frustration was particularly addressed towards the perceived expense, and attention, paid to nurses soon to be imported to Canada, especially when some nurses reported being unable to obtain full-time employment.

Recommendations:

i) Investigate retention of benefits when moving between RHAs or employers.

ii) Given the current national and international marketing campaigns, the Nurses Recruitment and Retention Fund Committee develop aggressive retention strategies.

- ***"Focus first on those who you have" was a widespread theme among practicing nurses in Manitoba. Nurses indicated that they are just "hanging on." Attention to the work satisfaction and working conditions of nurses in the system was considered imperative to retention.***

Part 4: Additional Recommendations

- ***Local consultation including RHAs, nurses and community leaders as appropriate, occurs on implementation strategies to improve worklife issues.***

Local solutions

Local variations were noted in the specific characteristics and manifestations of the issues and optimal solutions. Solutions to the issues, recommendations and pilot projects included in this report rely on individualized, local solutions such as local opinion and funding, and upon collaboration between the RHAs and nurses to determine what is best for that particular region and work site. Communities may also have valuable input into solutions for some of the issues such as day care, housing and security.

Recommendation:

i) Local consultation including RHAs, nurses and community leaders as appropriate, occurs on implementation strategies to improve worklife issues.

Implementation of Worklife Task Force recommendations

Some RHAs and nursing stakeholders have also studied issues related to worklife issues of nurses. These results should be integrated into the implementation of solutions to the issues generated in this report to maximize the comprehensiveness of the solutions and prevent duplication of research. Provincially these include, but are not limited to: a survey by the Parkland RHA of worklife issues, not yet completed; a survey by the Victoria General Hospital of Worklife issues in 1999; WRHA Mental Health Inpatient Staff Satisfaction Survey (October 2000); the MARN and MNRI study of non-practicing nurses; WRHA study of satisfaction of LPNs and RNs in Home Care; an RPNAM study (1999) on the "Vicarious Traumatization and Burnout in Registered Nurses in Manitoba" soon to be finalized; the Churchill RHA recruitment and retention survey, and a report of retention and recruitment issues in isolated First Nations communities by the Aboriginal Nurses Association of Canada and the First Nations and Inuit Health Branch. National examples of worklife studies include the efforts of the Calgary Regional Health Authority.

The MARN "Discussion paper on supportive practice environments" describes the use of tools developed by the Registered Nurses Association of British Columbia and the College of Nurses of Ontario for assessing and implementing plans for improving the workplace environment. The submission by MARN indicated that MARN anticipates the piloting and evaluation of a Supportive Practice Environment Program process in winter 2001, recommending the "development of a resource and support network throughout Manitoba to allow sharing of information and provide support."

One of the three strategic priorities of the Office of Nursing Policy in Health Canada is "Optimizing the potential of nursing human resources, with particular attention to the Health of Nurses; and Healthy Nursing Workplaces."

Recommendations:

i) The report from the Advisory Committee on Health Human Resources (ACHHR) to the Conference of Deputy Ministers/Ministers of Health in October 2000 recommended the formation of a Provincial Nursing Advisory Committee. Until the formation of this committee, the Provincial Nursing Resources Task Force be requested to consider:

a) investigating the feasibility and accountability of implementing the recommendations;

b) overseeing the implementation of this report;

c) determining follow-up evaluation; and

d) explore linkages with the federal Office of Nursing Policy to facilitate sharing of initiatives and strategies.

The Provincial Nursing Resources Task Force consists of representatives from regulatory bodies, educational institutions, unions, employers and health care aides.

ii) That there is open and full collaboration and resource distribution between RHAs and nursing organizations on the study, development, implementation or evaluation of strategies to address worklife issues via the Provincial Nursing Resources Task Force or its successor.

Task Force strategy

Nurses also provided feedback to the Task Force regarding the strategy. Stamped, self-addressed envelopes were integral to some nurses' participation and sense of valuing. The purpose or role of the Task Force was not felt to be clearly defined. A dedicated Web page that could be updated by the Task Force as needed would have eased consistent and timely communication. The skepticism of the nurses' experience with previous initiatives suggests that nurses must receive complete and timely feedback regarding their input to initiatives. Similarly the majority of nurses expressed interest in accessing the full report.

At the request of the RHAs, the survey was additionally analyzed per RHA. The RHAs of Burntwood and Churchill were analyzed collectively to preserve the anonymity of respondents. The survey results were also analyzed per professional designation.

Recommendations:

i) A mechanism for request of survey analysis per region or professional designation is made available through the Workforce Policy and Planning Branch, Manitoba Health

ii) The Task Force report is made publicly available by May 15, 2001 through a variety of mechanisms such as a Web page or through the regulatory bodies.

iii) A written copy of the Executive Summary in both official languages should be made available to nurses upon request to the Workforce Policy and Planning Branch of Manitoba Health.

iv) Future initiatives consider clarity and accessibility of communication.

v) Future surveys include self-addressed stamped envelopes and utilize standardized survey instruments with proven reliability and validity.

Long-term human resource planning and forecasting

Underlying all worklife issues was the need for dedicated human resource planning and forecasting utilizing a formal projection model on a long-term provincial basis. The cyclical nature of nursing employment includes perceived overages, which are then followed by cutbacks and subsequent nursing shortage (ACHHR, 2000). Specific Manitoba predictions and subsequent planning must be based on a comprehensive strategy including but not limited to population demographics; health services commitments and utilization; supply and population needs; and aging of the nursing workforce. A long-term and accurate forecasting and plan should cross the boundaries of political parties, electoral terms and nursing bodies. Retirement projections must also be specific to the practice area, assessing for differential retirement forecasts in different practice areas and regions.

The submission from the LTCAM (Long-Term Care Association of Manitoba) further recommended that long-term planning include the departments of Health, Education and Labour; a review of the immigration process; and consideration of the lack of parity in salary ranges and employee benefits provincially. As per the submission by the MNU in the MNU Health Care Report of 1998, the total out-migration of RNs in the early '90s exceeded the total

• ***The skepticism of the nurses' experience with previous initiatives suggests that nurses must receive complete and timely feedback regarding their input to initiatives.***

• ***Underlying all worklife issues was the need for dedicated human resource planning and forecasting utilizing a formal projection model on a long-term provincial basis.***

• ***A long-term and accurate forecasting and plan should cross the boundaries of political parties, electoral terms and nursing bodies.***

numbers of new registrants, including new Manitoba graduates. The University of Manitoba
(U of M) recommends that a human resource plan incorporate planning for an anticipated graduation of 450 to 500 registered nurses in Manitoba in 2002. The U of M expressed concern that such graduates may again leave Manitoba if full-time employment is unavailable.

Recommendations:

i) Long range human resource planning and forecasting model of nursing be coordinated and implemented provincially by Manitoba Health and RHAM.

ii) The utilization of support staff and interrelated health occupational groups should be considered in long-term human resource planning.

Bibliography

Reports

Advisory Committee on Health Human Resources (2000). The Nursing Strategy for Canada. Downloaded from the World Wide Web: *http://www.hc-sc.gc.ca/english/nursing/*

Canadian Council on Social Development (2000). *Labour market integration of graduates of nursing in Canada, 1986 to 1997.* Ottawa: Canadian Nurses Association.

Canadian Institute for Health Information (2000). *Canadian Institute for Health Information (CIHI) reports continued drop in registered nurses per capita and aging workforce* (press release). Downloaded July 22, 2000 from the World Wide Web: http://www.cihi.ca/medris/19July2000.htm

Canadian Nurses Association (1995). *The quality of nurses' worklife (policy statement).* Ottawa: Canadian Nurses Association.

Canadian Nurses Association (1997). *The future supply of registered nurses in Canada: A discussion paper.* Ottawa: Canadian Nurses Association.

Canadian Nurses Association (1998). *Registered nurse human resources: Recruitment and retention issues, a discussion paper.* Ottawa: Canadian Nurses Association.

Catalyst Research and Communications (2000). *ANAC survey of nurses in isolated First Nations Communities: Recruitment and retention issues.* Draft final report April, 2000. Submitted by Health Canada. Final report completed in December 2000.

Churchill Regional Health Authority, Recruitment and Retention Working Group (1999). *Recruitment/retention document.* Submitted by the Provincial Health Programs and Services Executive Network of the RHAs of Manitoba (RHAM).

College of Nurses of Ontario Quality Assurance Program (1999). *Building quality practice settings.*

Commonwealth of Australia (2000). *Rethinking nursing: National nursing workforce forum.* Canberra: Commonwealth of Australia, Commonwealth Department of Health and Aged Care. Downloaded from the World Wide Web http://www.health.gov.au/workforc/nursing/pdfcover/nnwfcov.htm

Education Services, South Westman Regional Health Authority (2000). *Education Connection, 1(1).* Souris: South Westman Regional Health Authority.

First Nations and Inuit Health Branch (May 05, 2000). *Summary of threat risk assessments, Manitoba region nursing stations.* Submitted by First Nations and Inuit Health Branch.

Health Canada, Office Of Nursing Policy (2000). *Strategic Priorities 2000 – 2001.* Ottawa: Office of Nursing Policy, Policy and Consultation Branch, Health Canada.

Health Promotion Directorate, Health Services and Promotion Branch Health and Welfare Canada (1991). *Corporate Health Model: A Guide to Developing and Implementing the Workplace Health System in Medium and Large Businesses.* Downloaded on October 15, 2000 from the World Wide Web: http://www.hc-sc.gc.ca/hppb/ ahi/workplace/partners/pube/corporatehealth/model.htm

Interlake Regional Health Authority (2000). *Recruitment/retention strategies – Report on employee recommendations.* Prepared for Interlake Health Authority Regional Resource Planning Committee by Van Helden, M.

Manitoba Association of Registered Nurses. *Discussion paper on supportive practice environments.* Winnipeg: Manitoba Association of Registered Nurses.

Manitoba Nurses Union (April 1996). *Occupational stress project report.* Submitted to the Worklife Task Force by the Manitoba Nurses Union.

Manitoba Nurses Union (April 1998). *Health care report.* Submitted to the Worklife Task Force by the Manitoba Nurses Union.

Manitoba Nurses Union (May 2000). *Long-term care report.* Submitted to the Worklife Task Force by the Manitoba Nurses Union.

Marquette Regional Health Authority (2000). *MRHA Nursing recruitment and retention strategy.* Submitted to the Worklife Task Force by the Provincial Health Programs and Services Executive Network.

Nursing Corporate Support Calgary Regional Health Authority (CRHA) (1999). *Worklife satisfaction survey of staff nurses CRHA acute care.* Submitted by the Manitoba Association of Registered Nurses.

O'Brien-Pallas, L, Irvine, D., Peereboom, E. & Murray, M. (1997). *Nursing Economics, 15(4), 171-182.*

O'Brien-Pallas, L., Baumann, A., Donner, G., Gerlach, J. L., Luba, Ml, Lakats, L., Amarsi, Y. & Mallette, C. (1998). *Health human resources: An analysis of forecasting models.* Ottawa: Canadian Nurses Association and Health Canada.

O'Brien-Palls, L. (2000). *Creative solutions in health care human resources.* Presentation to Manitoba Association of Registered Nurses on October 05/00. Submitted by Manitoba Association of Registered Nurses.

Pagliccia, N., Wood, L. & Kazanjian, A. (1993). *Nursing Resource Models: Part 1: Synthesis of the literature and a modeling strategy for BC* Health Human Resources Unit, Centre for Health Services and Policy Research, University of British Columbia.

Pearson, C. (2000). *Thoughts for recruitment and retention strategies: Continuing education and staff development.* Central Regional Health Authority, Manitoba.

Picot, G. & Wannell, T. (1996). *Linking outcomes for workers to changes in workplace practices: An experimental Canadian workplace and employee strategy.* Ottawa: Statistics Canada, Business and Labour Market Analysis Division.

Department of Health and Social Services, Prince Edward Island, (April 2000). *Recruitment and retention plan for Registered Nurses on Prince Edward Island.* Prepared by HR Associates Inc.

Registered Psychiatric Nurses Association of Manitoba and the Manitoba Developmental Centre (2000). *Final report: Pilot project on continuing competence.* Prepared by Crawford, J. & Tarko, M. Submitted by the Registered Psychiatric Nurses Association of Manitoba

Registered Psychiatric Nurses Association of Manitoba Board of Directors and Advisory Council (2000). *Impact of mental health reform on psychiatric nursing: Educational needs of Registered Psychiatric Nurses for continuing competency.* Prepared by Ryan-Nicholls, K. Submitted by Registered Psychiatric Nurses Association of Manitoba.

Strelioff, S. (chair). Nursing Task Force, Ministry of Health and Long-Term Care, Government of Ontario. *Good Nursing, Good Health: An investment in the 21st century.* Report of the Nursing Task Force (summary), January 1999. Downloaded from the World Wide Web http://www.gov.on.ca/MOH/english/pub/ministry/nurserep99/toc.html

Registered Nurses Association of British Columbia (1995). *Supporting agencies supporting nurses: The agency consultation program.* Vancouver: Registered Nurses Association of British Columbia.

Registered Nurses of Ontario, Registered Practical Nurses of Ontario (2000). Ensuring the care will be there: Report on nursing recruitment and retention in Ontario. Submitted to the Ontario Ministry of Health and Long-Term Care. Downloaded from the World Wide Web http://www.rnao.org/R&R_Full_Report050100.pdf

Wilkings, K. and Beaudet, M. P. (1998). *Work stress and health.* In Statistics Canada, Health Reports, 10(3), 47 - 63. Downloaded from the World Wide Web http://www.statcan.ca/cgi-bin/downpub/listpub.cgi?catno=82-003-XIE

Literature

Adams, A. & Bond, S. (2000). Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing, 32*(3), 536-543.

Bednash, G. (2000). The decreasing supply of registered nurses. Inevitable future or call to action? *JAMA, 283*(22), 2985-2987.

Buchan, J. (1999). Still attractive after all these years? Magnet hospitals in a changing health care environment. *Journal of Advanced Nursing, 30*(1), 100-108.

Buerhaus, P. I., Staiger, D. O. & Auerbach, D. I. (2000). Implications of an aging registered nurse workforce. *JAMA, 283*(22), 2948-2954.

Burke, R. J., & Greenglass, E. R. (1999). Work-family congruence and work-family concerns among nursing staff. *Canadian Journal of Nursing Administration, 12*(2), 21-29.

Burke, R. J. & Greenglass, E. R. (2000). Work concerns, family concerns. *The Canadian Nurse, 96*(9), 20-23.

Campbell, R. P. (1986). Does management style affect burnout? *Nursing Management, (Critical Care Management Edition), 17*(3), 38A - 38H.

Chaboyer, W., Williams, G., Corkill, W. & Creamer, J. (1999). Predictors of job satisfaction in remote hospital nursing. *Canadian Journal of Nursing Administration, 12*(2), 30-40.

Cheng, Y., Kawachi, I., Coakley, E. H., Schwartz, J. & Colditz, G. Association between psychosocial work characteristics and health functioning in American women: Prospective study. *BMJ, 320,* 1432-1436.

Davis, B., & Thornburn, B. (1999). Quality of nurses' worklife: strategies for enhancement. *Canadian Journal of Nursing Leadership, 12*(4), 11-15.

Edgar, L. (1999). Nurses' motivation and its relationship to the characteristics of nursing care delivery systems: A test if the job characteristics model. *Canadian Journal of Nursing Leadership, 12*(1), 14-21.

Freeman, T. & O'Brien-Pallas, L. L. (1998). Factors influencing job satisfaction on specialty nursing units. *Canadian Journal of Nursing Administration, 11*(3), 25-51.

Guadine, A. P. (2000). What do nurses mean by workload and work overload? *Canadian Journal of Nursing Leadership, 13*(2), 22-27.

Gleason Scott, J., Sochalski, J. & Aiken, L. (1999). Review of magnet hospital research: Findings and implications for professional nursing practice. *Journal of Nursing Administration, 29*(1), 9 - 19.

Goodyear Whiteley, E. M. (1999). *Retention of nurses: A review of the literature.* Prepared for the Winnipeg Hospital Authority. Submitted by the Winnipeg Regional Health Authority.

Griffiths, H. (1999). Finding support through RNABC's consultation program. *NursingBC,* March-April, 18-20.

Hastings, C. (1995). Differences in professional practice model outcomes: The impact of practice setting. *Critical Care Nursing Quarterly, 18*(3), 75-86.

Irvine, D. M. & Evans, M. G. Job satisfaction and turnover among nurses: Integrating research findings across studies. *Nursing Research, 44*(4), 246-253.

Kane, D. (1999). Job sharing: A retention strategy for nurses. *Canadian Journal of Nursing Administration, 12*(4), 16-22.

Kangas, S., Kee, C. C. & McKee-Waddle, R. (1999). Organizational factors, nurses' job satisfaction, and patient satisfaction with nursing care. *Journal of Nursing Administration, 29*(1), 32-41.

Kramer, M. & Schmalenberg, C. (1991). Job satisfaction and retention: Insights for the '90s, Part 1. *Nursing91,* 21(3), 50-55.

Kramer, M. & Schmalenberg, C. (1991). Job satisfaction and retention: Insights for the '90s, Part 2. *Nursing91,* 21(4), 51-55.

Laschinger, H. K. S & Havens, D. S. (1996). Staff nurse work empowerment and perceived control over nursing practice. *Journal of Nursing Administration, 26*(9), 27-35.

Laschinger, H. K. S & Havens, D. S. (1997). The effect of workplace empowerment on staff nurses' occupational mental health and work effectiveness. *Journal of Nursing Administration, 27*(6), 42-50.

Laschinger, H. K. S. & Shamian, J. (1994). Staff nurses' and nurse managers' perceptions of job-related empowerment and managerial self-efficacy. *Journal of Nursing Administration, 24*(10), 38-47.

Laschinger, H. K. S. & Wong, C. (1999). Staff nurse empowerment and collective accountability: Effect on perceived productivity and self-rated work effectiveness. *Nursing Economics, 17*(6), 308-316.

Laschinger, H. K. S. & Sabiston, J. A. (2000). Staff nurse empowerment and workplace behaviours. *The Canadian Nurse, 96*(2), 18-22.

Levack, M. L. & Jones, C. B. (1996). The nursing practice environment, staff retention, and quality of care. *Research in Nursing and Health, 19,* 331-342.

Lynn, M. R. & Kelley, B. (1997). Effects of case management on the nursing context - perceived quality of care, work satisfaction, and control over practice. *Image: The Journal of Nursing Scholarship, 29*(3), 237-241.

Marion, C. D., Matthews, J. L., Kirkpatrick, C. & Goulding Streifel, J. (1995). Focus on autonomy: Supporting an innovative, empowered staff. *Critical Care Nursing Quarterly, 18*(3), 21-27.

Mayo, A. M. & Van Slyck, A. (1999). Developing staffing standards: Statistical considerations for patient care administrators. *Journal of Nursing Administration, 29*(10), 43-48.

McDermott, K., Laschinger, H. K. S. & Shamian, J. (1996). Work empowerment and organizational commitment. *Nursing Management, 27*(5), 44-47.

McGilton & Pringle, D. M. (1999). The effects of perceived and preferred control on nurses' job satisfaction in long term care environments. *Research in Nursing and Health, 22,* 251-261.

McGirr, M, & Bakker, D. A. (2000). Shaping positive work environments for nurses: The contributions of nurses at various organizational levels. *Canadian Journal of Nursing Leadership, 13*(1), 7-14.

McNeese-Smith, D. K. (1999). A content analysis of staff nurse descriptions of job satisfaction and dissatisfaction. *Journal of Advanced Nursing, 29*(6), 1332-1341.

McNeese-Smith, D. K. (2000). Job stages of entry, mastery, and disengagement among nurses. *Journal of Nursing Administration, 30*(3), 140-147.

McSwain, K, Robinson, R. & Panteluk, L. (April 17th, 1998). *Annotated bibliography on vicarious traumatization and forms of traumatic stress in the workplace of psychiatric nurses.* Poster session presented at the RPNAM annual poster session competition, Selkirk, Manitoba. http://www.rpnam.mb.ca/vt.html. Submitted by the Winnipeg Regional Health Authority.

Medley, F. & Larochelle, D. R. (1995). Transformational leadership and job satisfaction. *Nursing Management, 26*(9), 64JJ-64NN.

Meisner, T., Haddock, K. S., Gleaton, J. U. & Ajamieh, A. R. A. (1996). Toward an internal measure of job satisfaction. *Nursing Research, 45*(2), 87-91.

Mills, A. C. & Blaesing, S. L. (2000). A lesson from the last nursing shortage; The influence of work values on career satisfaction with nursing. *Journal of Nursing Administration, 30*(6), 309-315.

Misener, T. R., Haddock, S., Gleaton, J. U. & Ajamieh, A. R. (1996). Toward an internal measure of job satisfaction. *Nursing Research, 45*(2), 87-91.

Moss, R. & Rowles, C. J. (1997). Staff nurse job satisfaction and management style. *Nursing Management, 28*(1), 23-34.

Nicklin, W. (2000). "Thank you" isn't enough. *Healthcare Management Forum, 13*(3), 6-9.

National Institute for Occupational Safety and Health (NIOSH)(1999). *Stress... at work.* US Department of Health and Human Services. Retrieved on October 23, 2000 from the World Wide Web http://www.cdc.gov/niosh/atwork.html

Nones Cronin, S. & Becherer, D. (1999). Recognition of staff nurse job performance and achievements: Staff and manager perceptions. *Journal of Nursing Administration, 29*(1), 26-31.

Perry, B., McKee, G. & Selmser, P. (2000). Nursing skills enhancement. *The Canadian Nurse, 96(9),* 24-27.

Ptasznik, E. (1999). *Issues related to the retention of registered nurses.* Unpublished manuscript. Submitted by the Winnipeg Regional Health Authority.

Sabiston, J. A. & Laschinger, H. K. S. (1995). Staff nurse work empowerment and perceived autonomy. *Journal of Nursing Administration, 25*(9), 42-50.

Sibbald, B. (1999). RN = Really neglected, angry nurses say. *CMAJ, 160,* 1490-1491.

Slavitt, D. B., Stamps, P. L., Piedmont, E. B. & Haase, A. B. (1978). Nurses' satisfaction with their work situation. *Nursing Research, 27*(2), 114-120.

Spector, P. E. (1985). Measurement of human staff satisfaction: Development of the job satisfaction survey. *American Journal of Community Psychology, 13*(6), 693-713.

Spurgeon, D. (2000). Canada faces nursing shortage. *BMJ, 320,* 1030.

Stratton, T. D., Dunkin, J. W., Juhl, N. & Geller, J. M. (1995). Retainment incentives in three rural practice settings: Variations in job satisfaction among registered nurses. *Applied Nursing Research, 8*(2), 73-80.

Tovey, E. J. & Adams, A. E. (1999). The changing nature of nurses' job satisfaction: An exploration of sources of satisfaction in the 1990s. *Journal of Advanced Nursing, 30*(1), 150-158.

Other

Calgary Regional Health Authority Nursing Worklife Satisfaction Survey. *Literature Review.* Submitted by the Manitoba Association of Registered Nurses,

Department of Health and Human Services, Heath Resources and Services Administration (1999). *Health WorkForce Newslink, 5*(4). Downloaded from the World Wide Web http://bhpr.hrsa.gov/healthworkForce/newslink.htm

Department of Health and Human Services, Heath Resources and Services Administration (2000). *Health WorkForce Newslink, 6*(4). Downloaded from the World Wide Web http://bhpr.hrsa.gov/healthworkForce/newslink.htm

Harvard School of Public Health. *Job stress taxes health.* Press release of May 26, 2000. Downloaded from the WWW: http://www. hsph.Harvard.edu/press/releases/press0562000.html

Health Sciences Centre. *Critical Incident Stress Management Program* (brochure).

MARN Supportive Practice Environments (1999). *Summary notes on bibliography.* Manitoba: Manitoba Association of Registered Nurses, August 30, 1999.

Manitoba Association of Registered Nurses (2000). *MARN Supportive Practice Environments – Bibliography list.* Manitoba: Manitoba Association of Registered Nurses, October, 2000.

Manitoba Nursing Union. *List of suggested readings.* Submitted to the Worklife Task Force by the Manitoba Nurses Union.

St. Boniface General Hospital. *Critical Incident Stress Management Program* (brochure).

Appendices

Appendix a:

News Release

March 1, 2000

FIVE-POINT PLAN ANNOUNCED TO ADDRESS NURSING ISSUES

Health Minister Dave Chomiak today introduced a five-point plan designed to help Manitoba's health sector to reinvest in the nursing profession by attracting new students, recruiting more nurses and looking at the use of existing staff resources within the workforce.

"This plan offers the first comprehensive approach to dealing with Manitoba's nursing shortage in the past 10 years," Chomiak said. "Our government has worked with front-line nurses to look at challenges and opportunities, including the issues of educating, hiring and keeping nurses in the workforce, and how they work within the system. We believe our approach will be successful because it is not limited to a single initiative or action.

"The provincial government values the contribution of all nurses, and we will try to attract both students and staff for all three major nursing professions, including diploma and degree prepared registered nurses (RNs), registered psychiatric nurses (RPNs) and licensed practical nurses (LPNs)."

As part of the comprehensive recruitment and retention effort, the costs of relocation and refresher courses for nurses wanting to re-enter the workforce are available to all three groups.

The provincial government, with its five-point plan, will:

Increase the supply of nurses in Manitoba to match current and anticipated labour market demand

- The government will support a 23-month diploma RN program as an alternative for students preparing for a career in nursing. The program complements the University of Manitoba's bachelor of nursing (BN) program. Both diploma and degree education programs will give graduates the knowledge and skills they need to be licensed as RNs.
- More LPNs will enter the workforce because of increased enrolment in the Assiniboine Community College LPN program. The number of students accepted was earlier increased from 90 to 190 students per year, and access was improved by delivering courses in two rural locations, Carman and Killarney, as well as in Winnipeg and Brandon.
- The province will actively recruit students to nursing education and the nursing profession. Recruitment efforts will include a marketing campaign to target youth and under-represented groups such as aboriginal students, men and members of multi-cultural communities.
- The province will aggressively recruit nurses within Manitoba who are not currently employed in their field.

- A national and international recruitment strategy will be implemented in association with the Regional Health Authorities of Manitoba to hire additional nurses.

Improve access to staff development in the regional health authorities

- Regional Health Authorities (RHAs) will receive a combined total of $3 million for staff development, based on the number of RNs, RPNs and LPNs living in each region. A committee made up of employers and front-line nurses will be established in each region to identify continuing education needs and priorities such as changes in nursing practice or treatment and working with new equipment.

Improve the use of available nursing resources

- Manitoba Health is working with employers, unions and front-line staff to identify and resolve issues that may create barriers to full-time permanent jobs for those who want them.
- The government is also directing RHAs to change the staffing mix within health facilities to allow more flexibility in hiring practices, such as adding more LPNs to the mix. The Seven Oaks Hospital currently employs LPNs in acute care, and Concordia Hospital plans to add LPNs to its staffing mix this spring.

Improve working conditions

- The health system has relied heavily on overtime and extended shifts to staff hospital beds, resulting in heavy workloads, high levels of illness and dissatisfaction and burnout. Through a joint initiative with Manitoba Labour and Manitoba Health, the government will establish a three-member team to address quality of life issues that affect working conditions and the overall workplace environment. This group will also be asked to identify specific pilot projects that would improve working conditions and morale.

Establish a nursing advisory council

- A council of labour, management and educators from across the province will advise the health minister on issues and concerns related to the role of nursing in the health care system.

The province will also amend an existing regulation to give nurses and other health care providers the opportunity to have a voice on health facility boards and regional health authorities.

Appendix b:

News Release

May 3, 2000

TASK FORCE NAMED TO EXAMINE WORKING CONDITIONS FOR NURSES

Health Minister Dave Chomiak has named a three-member task force with the mandate to examine issues that affect nurses' working conditions and their workplace environment.

Speaking at the Manitoba Nurses' Union (MNU) annual general meeting this morning, Chomiak said the task force, a joint initiative with Manitoba Labour and Manitoba Health, will address non-monetary issues faced by nurses in a variety of work settings.

Members include MNU representative and nurse Brenda Lesyk of Warren, Patricia Cockburn, vice-president of programs and services for the Marquette Regional Health Authority, of Neepawa, and Anne Wright, a retired nurse, from Brandon.

"Our government's long-term goal is to ensure high quality patient care. Providing a good quality of life for nurses in the workplace will help us achieve that goal," Chomiak said. "As part of the five-point plan for nursing that I announced March 1, this task force will talk to nurses and other health care providers, hear their concerns and look at opportunities for improvement."

Over the next six to eight months, task force members will focus on four major tasks:

- identifying factors contributing to job dissatisfaction;
- identifying causes of workplace and personal stress for nurses (such as a lack of mentors, limited or no input into decision-making, increased workload demands, and caring for children and elders at home);
- developing proposals to address the most significant issues affecting job satisfaction; and
- overseeing the development and implementation of pilot projects to evaluate initiatives that may improve job satisfaction.

Successful pilot projects will provide an objective basis for changes that can be made in workplaces throughout the province, the minister said.

"I made a personal commitment to the nursing community and to the people of Manitoba to support necessary changes that would allow nurses to do their jobs in a more pleasant and rewarding environment," Chomiak said. "I know this initiative has an excellent chance to succeed because the solutions will be planned, pilot tested and implemented by nurses and administrators on behalf of their co-workers and colleagues."

Biographies

Brenda Lesyk

Brenda Lesyk was born and raised in Warren, Man., where she currently resides. After graduating from the Winnipeg General Hospital School of Nursing as an RN in 1974, she worked at the Health Sciences Centre as a general duty nurse. She has had a variety of work experiences at that facility throughout the years, including positions in the Children's Pediatric Intensive Care Unit. She has worked in the Children's Post Anaesthesia Care Unit for the past 16 years.

This is Lesyk's first year as an MNU provincial board representative. She was previously on the Manitoba Association of Registered Nurses (MARN) board from 1998-1999. Lesyk has been active in the Health Sciences Centre Local since 1987, working on various committees including finance, political action/labour education, nursing advisory, and workplace health and safety. During this 13-year period she also participated in many nursing workshops and conferences.

Patricia Cockburn

Patricia Cockburn is a graduate of the University of Manitoba Bachelor of Nursing Program, and holds a masters' degree in health care administration from the University of Minnesota. Cockburn grew up in Emerson, Man., but has lived in Neepawa since 1988. Since 1997, she has been vice-president of programs and services with the Marquette Regional Health Authority.

Cockburn has worked in a variety of facilities including Victoria Hospital, Emerson/Morris hospitals, Seven Regions Health Centre, Neepawa Hospital and East View Lodge. She has been employed in an administrative capacity for 17 years, but has also held front-line positions on a surgical floor, in a small rural facility, and in community health settings such as home care and public health.

Cockburn is currently a member of the MARN Continuing Competency Committee. She also sits on the Cancer Capacity Planning Study Steering Committee through Cancer Care Manitoba and is a member of the Provincial Nursing Resources Task Force.

Anne Wright

Anne Wright graduated as an LPN in 1966 and as an RN in 1976. She worked in the hospitals in Ste. Rose and Killarney, Man. In 1981, she moved to Brandon where she currently resides. Wright worked in the emergency room at Brandon Hospital for 19 years prior to her retirement in January of this year.

Wright has been actively involved in the MNU since 1982 in several capacities. Most recently, she served as president of the local union for three years. She has performed volunteer work for various organizations, including the Heart and Stroke Foundation. She has also helped organize nurses to serve as volunteer first aid responders at several sporting events in Manitoba, including the Manitoba Summer Games. She has been involved in the Cardiac Reh-Fit program at the Brandon Y for 17 years and continues to be active in that program.

Appendix C:

Terms of Reference

WORKLIFE TASK FORCE

Purpose:

To address non-monetary issues affecting nurses' working conditions and workplace environment.

Activities:

- Identifying workplace and personal stressors for nurses (e.g., lack of mentors, lack of input into decision-making, child and elder care, etc.)
- Identifying factors contributing to job satisfaction.
- Developing proposals to address the most significant issues affecting job satisfaction.
- Identifying initiatives to be assessed as pilot projects before being implemented on a broader basis.

Membership:

- Independent chair
- MNU representative
- Representative of Employers (e.g., a vice-president, clinical programs, from a health authority)
- Administrative support

Term:

- Six to eight months

Meetings:

- Meetings of Task Force shall be held at the call of the chair

Adopted on June 7, 2000

Schedule of General Meetings

Week 1

Monday Sept. 11 **Marquette RHA**	**Tuesday Sept. 12** **Marquette RHA**	**Wednesday Sept. 13** **Parkland RHA**	**Thursday Sept. 14** **Parkland RHA**	**Friday Sept. 15** **Brandon RHA**
Neepawa: Eastview Lodge PCH	Russell: Russell Ambulance Facility	Swan Valley: Community Health conference room	Dauphin: Dauphin Regional Health Centre	Brandon: Brandon Hospital
0830 to 1030	0830 to 1030	0830 to 1030	0830 to 1030	0815 to 1015
1330 to 1530	1330 to 1530	1330 to 1530	1330 to 1530	1330 to 1530
1930 to 2130	1930 to 2130	1930 to 2130	1930 to 2130	

Week 2

Monday Sept. 25 **Churchill RHA**	**Tuesday Sept. 26** **Burntwood RHA**	**Wednesday Sept. 27** **Nor Man RHA**	**Thursday Sept. 28** **Nor Man RHA**	**Friday Sept. 29**
Churchill Health Centre	Thompson Thompson Regional Health Centre	The Pas The Pas Health Complex	Flin Flon Flin Flon Hospital	
Individual meetings	0830 to 1030		0830 to 1030	
1330 to 1530	1330 to 1530	1330 to 1530 1530 Conference call with Snow Lake		
	Included conference call with Leaf Rapids, and Lynn Lake 1730 to 1930	1900 –2100		

Week 3

Monday Oct. 2 Winnipeg RHA	Tuesday Oct. 3 South Eastman RHA	Wednesday Oct. 4 South Eastman RHA	Thursday Oct. 5 North Eastman RHA	Friday Oct. 6 North Eastman RHA
		Steinbach: Betheseda Hospital and PCH	Beasejour: Eastgate Lodge PCH	Pine Falls: Pine Falls Health Complex
Victoria General Hospital 0730 to 0930 1000 to 1200	Sprague – East Borderland Primary Health Unit 1000 to 1130	0900 to 1100	0830 to 1030	0830 to 1030
Health Sciences Centre 1400 to 1600	Vita Hospital 1330 to 1530 PM	1300 to 1500	1330 to 1530	1330 to 1530
Manitoba Adolescent Treatment Centre 1900 to 2100	Vita Hospital 1930 to 2100	1930 to 2100	1930 to 2100	

Week 4

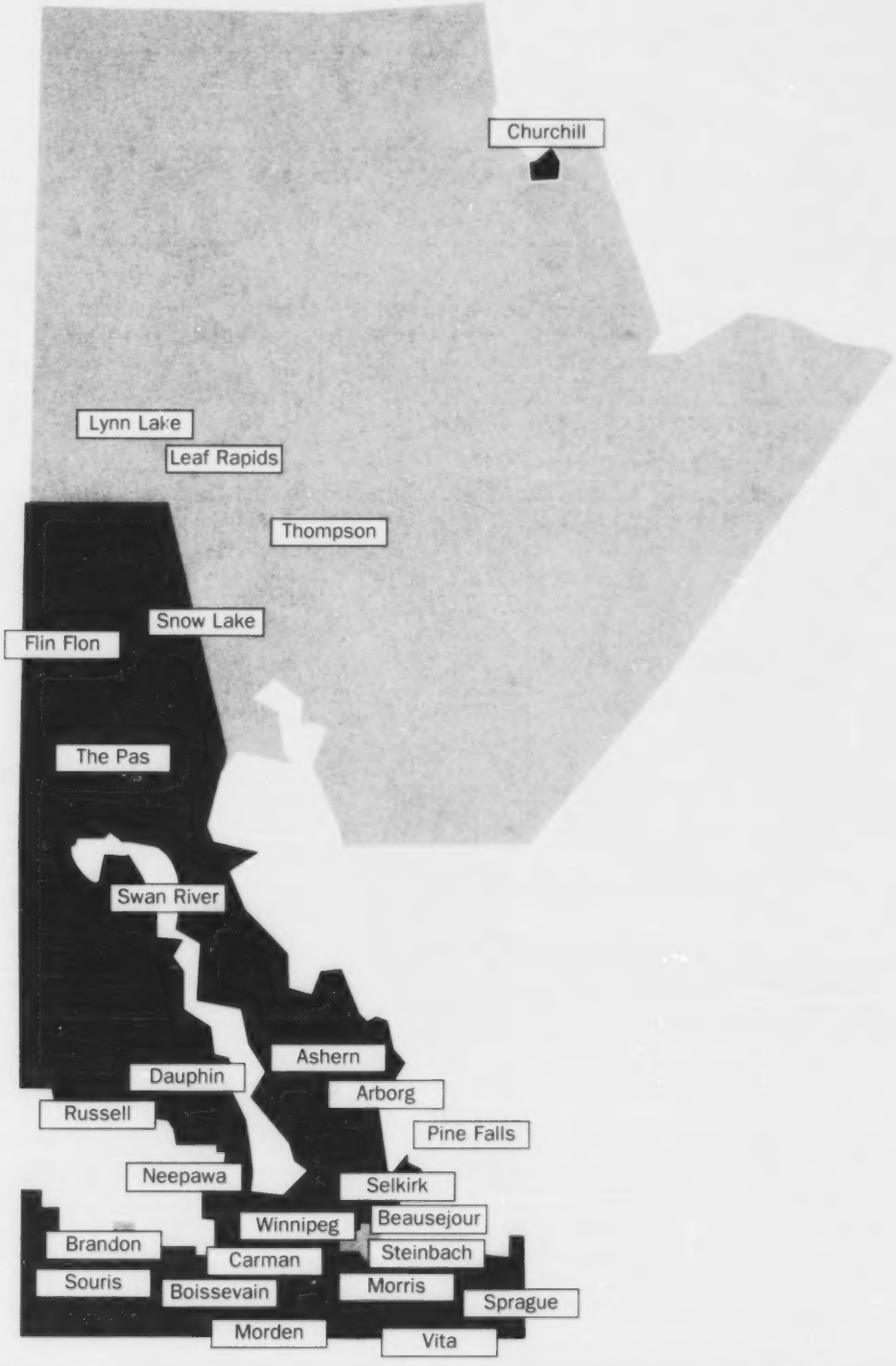
Monday Oct. 16 South Westman RHA	Tuesday Oct. 17 South Westman RHA	Wednesday Oct. 18 Brandon RHA	Thursday Oct. 19 Central RHA	Friday Oct. 20 Central RHA
Souris: Souris Hospital	Boissevain: Health Centre	Brandon: Fairview Personal Care Home	Morris: Morris District Hospital	
0830 to 1030	0830 to 1030	0815 to 1015	Portage la Prairie: Portage Hospital 0830 to 1030	0900 to 1100
1330 to 1530	1330 to 1530	1330 to 1530	Portage la Prairie 1330 to 1530	1200 to 1400
1930 to 2130	1930 to 2130	1930 to 2130	Carman: Carman Hospital 1930 to 2130	

Week 5

Monday Oct. 23 Central RHA	Tuesday Oct. 24 Interlake RHA	Wednesday Oct. 25 Interlake RHA	Thursday Oct. 26 Winnipeg RHA	Friday Oct. 27 Winnipeg RHA
Morden: Morden Hospital	Ashern	Selkirk and District Health Centre	Winnipeg	Winnipeg
0830 to 1030	0830 to 1030	0830 to 1030	Grace General Hospital 0730 to 0930 1000 to 1200	Concordia Hospital 0730 to 0930 1000 to 1200
1330 to 1530	Arborg 1400 to 1600	1330 to 1530	Riverview Health Centre 1400 to 1600	Health Sciences Centre 400 to 1600
	1930 to 2130	1930 to 2130	St. Boniface Hospital 1900 to 2100	

Appendix e:

Locations of General Meetings



Appendix f:

Notice of General Meetings

Renewing our Commitment to Nurses

The Worklife Task Force, established by the Minister of Health, invites you to meet with us to discuss your perceptions of nursing as a career.

All Nurses are invited to tell us:

- what positive and negative factors have an impact on the workplace satisfaction of nurses
- what are the major causes of stress that influence a nurses' ability to work
- what can be done to improve working conditions and increase job satisfaction

Please join us at one of the following Worklife Task Force meeting(s):

Date:

Location:

Time:

Date:

Location:

Time:

This is your opportunity to provide input into the development of recommendations to the Minister of Health on working conditions for all nurses in Manitoba.

NOTE: Surveys are being sent to you. You may either mail your responses to the Task Force, or hand them in to the Task Force at the meeting.

M121

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Attendance at General Meetings

Health Region	RN	LPN	RPN	Students	Professional Designation Unknown	Total Attendance
Brandon	32	3	4		1	40
Burntwood	17	4		1		22
Central	30	4	2		1	37
Churchill	7					7
Interlake	15	3	4		2	24
Marquette	24	5	3		2	34
Nor Man	20	5				25
North Eastman	11	3				14
Parkland	30	2	1		2	35
South Eastman	16	2				18
South Westman	20	9	1	6		36
Winnipeg	117	1				118
Total	**339**	**41**	**15**		**8**	**402**

Appendix g:

Attendance at General Meetings

Health Region	RN	LPN	RPN	Students	Professional Designation Unknown	Total Attendance
Brandon	32	3	4		1	40
Burntwood	17	4		1		22
Central	30	4	2		1	37
Churchill	7					7
Interlake	15	3	4		2	24
Marquette	24	5	3		2	34
Nor Man	20	5				25
North Eastman	11	3				14
Parkland	30	2	1		2	35
South Eastman	16	2				18
South Westman	20	9	1	6		36
Winnipeg	117	1				118
Total	**339**	**41**	**15**		**8**	**402**

Appendix h:

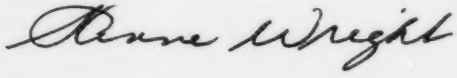
Survey

August, 2000

Dear Nursing Registrant:

On behalf of the Worklife Task Force, I thank you for taking the time to complete this questionnaire and return it to us by October 31, 2000 by mail to Worklife Task Force, c/o Workforce Policy & Planning Unit, 300 Carlton, Winnipeg, Manitoba, R3B 3M9 or in person, at the Task Force meeting in your region. Your comments will assist us in preparing a report to the Minister of Health in which we will be making recommendations, pertaining to the improvement of the working life of nurses, for his consideration.

Yours truly,



Anne Wright
Chair, Worklife Task Force

Background Information

Age: ☐ < 30 ☐ 31-40 ☐ 41-45 ☐ 46-50 ☐ 51-55 ☐ > 56

Gender: ☐ female ☐ male

Health Authority: ☐ Brandon ☐ Burntwood ☐ Central ☐ Churchill
☐ Interlake ☐ Marquette ☐ Norman ☐ North Eastman
☐ Parklands ☐ South Eastman ☐ South Westman ☐ Winnipeg

Employment Status: ☐ full-time ☐ part-time 0.1-0.5 E.F.T ☐ 0.6-0.9 E.F.T. ☐ casual

Are you seeking full-time employment? ☐ Yes ☐ No

Practice setting: ☐ in-patient facility/hospital ☐ long-term facility ☐ PCH ☐ community
☐ educational facility ☐ other _____(specify)

Area of responsibility: ☐ direct care provider ☐ other

Hours of work: ☐ days ☐ rotating shifts

Please indicate your level of agreement with the following statements

	Disagree 1	2	3	4	Agree 5
1. There are available human resources with appropriate expertise for consultation and education in your workplace or region.	☐	☐	☐	☐	☐
2. There are appropriate support resources, in sufficient numbers, for patient/client care outcomes, e.g., health care aides, housekeeping, maintenance, physicians, pharmacists, porters, security personnel, etc.	☐	☐	☐	☐	☐
3. There is nurse participation in decision-making at all levels of the organization.	☐	☐	☐	☐	☐
4. Nursing standards and ethics are supported and accepted.	☐	☐	☐	☐	☐
5. Support for the role of nursing is shown by immediate supervisor/manager.	☐	☐	☐	☐	☐
6. Supplies are sufficient to meet client/patient needs.	☐	☐	☐	☐	☐
7. Equipment to meet client/patient needs is readily available and in good working order.	☐	☐	☐	☐	☐
8. Patient/client information is easily accessible and retrievable. (e.g., medical records)	☐	☐	☐	☐	☐
9. Working relationships among health team members are positive and supportive.	☐	☐	☐	☐	☐
10. Work scheduling is flexible to allow for personal/professional responsibilities.	☐	☐	☐	☐	☐
11. The environment is safe for clients/patients.	☐	☐	☐	☐	☐
12. You feel secure and safe arriving and leaving your workplace.	☐	☐	☐	☐	☐
13. Your work environment is safe and secure for you and your colleagues.	☐	☐	☐	☐	☐
14. Non-work responsibilities contribute to personal stress.	☐	☐	☐	☐	☐
15. Do you feel that there are services, which if available, would assist in your family caregiving role?	☐ Yes	☐ No			

16. Please check those services which would assist you.

☐ Child Day Care ☐ Adult Day Care ☐ Respite Care ☐ Low cost meals to take home
☐ Improved Transportation to and from work ☐ Other suggestions _____

_____

17. Your work or workplace conditions contribute to work-related stress.	☐	☐	☐	☐	☐
18. Do you feel that there are resources, which if available, would assist you in decreasing your stress?	☐ Yes	☐ No			

19. Please check those supports which you feel would increase your job satisfaction and/or reduce personal stress:

☐ Self scheduling ☐ Increased clerical support ☐ Increased supervisory support
☐ On-site education sessions ☐ Fitness program ☐ Other suggestions _____

_____

20. Please give us any further suggestions that make your workplace more supportive. (Add paper if needed)

_____

_____

Appendix i:

Survey Characteristics

Table 1 • Number and Percentage of Respondents by Regional Health Authority

The following table indicates the number of participants per health authority, i.e., 9.6 % of participants indicated they were from Central RHA. The RHAs of Burntwood and Churchill were combined for survey analysis to preserve the anonymity of the small number of nurses from the Churchill RHA. The category "other" includes those nurses who indicated working in more than one health authority, or wrote in additional categories such as federal government or industry.

Identified employer by Regional Health Authority	Number of surveys returned/region	% of total surveys returned
Winnipeg	1292	50.3
Central	247	9.6
Brandon	181	7.0
Parklands	144	5.6
Interlake	133	5.2
Marquette	114	4.4
South Westman	110	4.3
South Eastman	105	4.1
Norman	67	2.6
Burntwood/Churchill	56	2.2
North Eastman	54	2.1
More than one health authority	19	0.7
Other (e.g., Federal gov't, industry, nonprofit org.)	15	0.6
No Response	33	1.3
Total	**2,570**	**100.0**

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No Response	33	1.3
Total	**2,570**	**100.0**

Survey Characteristics

Table 2 • Age Distribution of Respondents

The mean age group of the respondents was 41 to 45 years of age, comparable to the average age of registered nurses of 43 (CIHI, 2000). Table 1 illustrates the distribution of the ages of the respondents. Age was collected in grouped age ranges. The mean was within the 41-50 age group, with a median age group of 41-45 years old.

Age Group	No. of respondents	% of total respondents
30 years old or younger	183	7.1
31-40 years old	630	24.5
41-45 years old	531	20.7
46-50 years old	547	21.3
51-55 years old	431	16.8
56 years old or older	240	9.3
No Response	8	0.3
Total	**2,570**	**100.0**

Appendix i:

Survey Characteristics

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51-55 years old	431	16.8
56 years old or older	240	9.3
No Response	8	0.3
Total	**2,570**	**100.0**

Appendix i:

Survey Characteristics

Chart 1 • Respondents by Professional Designation

As seen in chart 1, of the total number of participants, 77.5% indicated they were RNs, as compared to 6.8% RPNs, 15.5% LPNs, and two or 0.1% where the professional designation was unknown.

Respondents by Designation (%)

(n=1,160)

Survey Characteristics

Table 3 • Employment Status of Respondents

The survey asked respondents to indicate whether they were working full-time, part-time (0.1-0.5 EFT or 0.6-0.9 EFT). Some respondents indicated more than one employment category, as seen in Table 3 below. Within the options provided in the survey regarding employment status, the largest category of employment status was nurses working full-time.

Employment Status	n=	%
Full-time	1,115	43.4
Part-time 0.1-0.5 EFT	557	21.7
Part-time 0.6-0.9 EFT	675	26.3
Casual	147	5.7
Part-time & casual	37	1.4
Full-time & casual	13	0.5
No response	26	1.0
Total	**2,570**	**100.0**

Appendix i:

Survey Characteristics

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Part-time & casual	37	1.4
Full-time & casual	13	0.5
No response	26	1.0
Total	**2,570**	**100.0**

Appendix i:

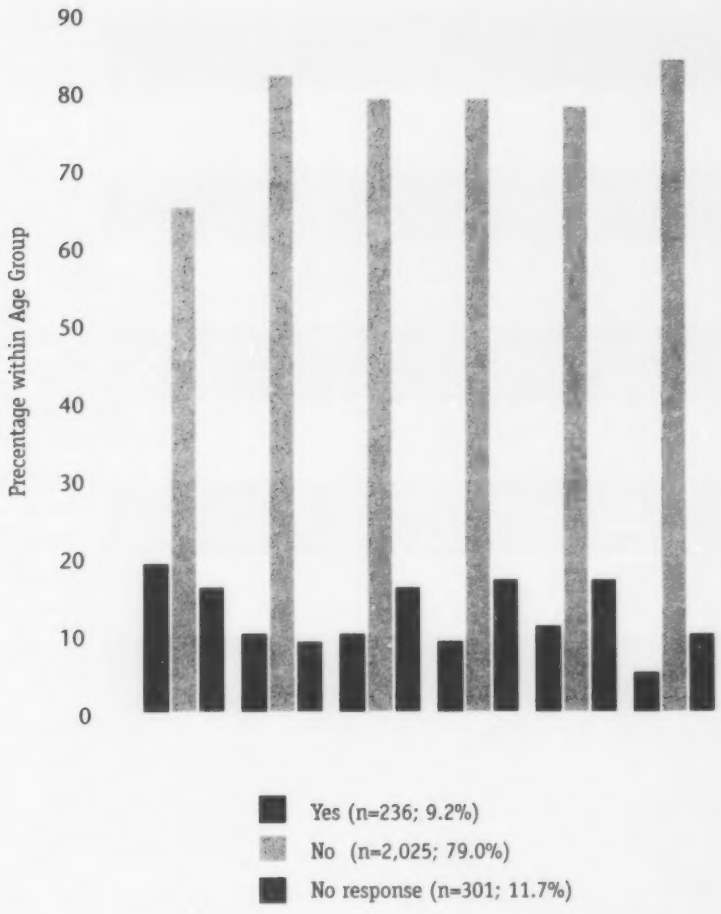
Survey Characteristics

Chart 2 • Are nurses seeking full-time employment (within age group)?

The majority of respondents indicated that they were not seeking full-time employment (79.0% compared to 9.2% who were, and 11.7% no response). Viewing age groups separately, a larger percentage of nurses 30 years of age or younger indicated that they were seeking full-time employment than any other age group.

Are you seeking full-time employment within Age Group (%)

(n=2,570)



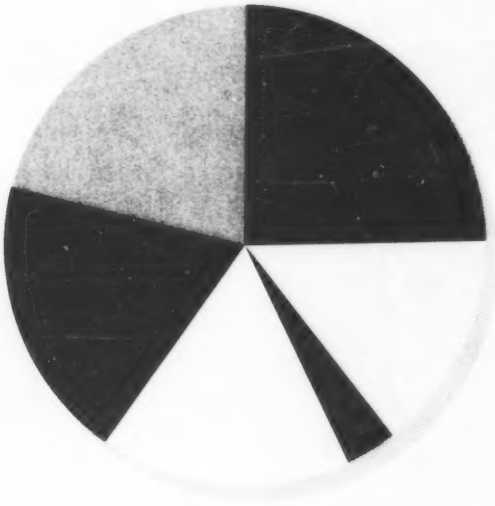
Survey Characteristics

Chart 3 • Seeking full-time employment (by age group)

Similarly, looking only at those nurses who indicated that they were seeking full-time employment, the majority were nurses 30 years of age or younger.

Seeking full-time employment (%)

(n=236)



30 years or younger (n=35; 14.8%)
31-40 years old (n=58; 24.6%)
41-45 years old (n=50; 21.2%)
46-50 years old (n=45; 19.1%)
51-55 years old (n=40; 16.0%)
56 years or older (n=8; 3.4%)

Survey Characteristics

Chart 4 • Working full-time and seeking full-time

Of those who indicated that they were seeking full-time employment, as indicated in chart 3, 54 nurses or 2.1% were already working full-time, possibly indicating a wish to change or amalgamate positions. The age groups with the largest number of nurses indicating this interest were those 31-40 years (25.9% of the 54) and 30 years or younger (20.4% of the 54).

Working full-time and seeking full-time by age group (%)

(n=54)

- 30 years or younger (n=11; 20.4%)
- 31-40 years old (n=14; 25.9%)
- 41-45 years old (n=9; 16.7%)
- 46-50 years old (n=11; 20.4%)
- 51-55 years old (n=8; 14.8%)
- 56 years or older (n=1; 1.9%)

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Survey Analysis

Table 4 • Level of agreement with the following statements among respondents

Responses ranged from 1 to 5, with 1=disagree and 5=agree.

Statement	Mean	Std dev	Range
1. There are available human resources with appropriate expertise for consultation & education in your workplace or region.	3.05	1.23	1-5
2. There are appropriate support resources, in sufficient numbers, for patient/client outcomes.	2.30	1.15	1-5
3. There is nurse participation in decision-making at all levels of the organization.	2.46	1.19	1-5
4. Nursing standards and ethics are supported and accepted.	3.23	1.15	1-5
5. Support for the role of nursing is shown by immediate supervisor/manager.	3.22	1.29	1-5
6. Supplies are sufficient to meet client/patient needs.	3.07	1.21	1-5
7. Equipment to meet client/patient needs is readily available and in good working order.	2.84	1.17	1-5
8. Patient/client information is easily accessible and retrievable.	3.58	1.05	1-5
9. Working relationships among health team members are positive and supportive.	3.02	1.15	1-5
10. Work scheduling is flexible to allow for personal/professional responsibilities.	2.86	1.31	1-5
11. The environment is safe for clients/patients.	3.19	1.15	1-5
12. You feel secure and safe arriving and leaving your workplace.	3.53	1.21	1-5
13. Your work environment is safe and secure for you and/or your colleagues.	3.32	1.16	1-5
14. Non-work responsibilities contribute to personal stress.	3.32	1.24	1-5
15. Your work or workplace conditions contribute to work-related stress.	3.97	1.13	1-5

Survey Analysis

Table 5 • Types of services selected by respondents who feel that there are services that would assist in their care-giving role (questions #15 and 16)

(n=1160)

Service	n=	%
Child day care	389	33.5
Low cost meals to take home	348	30.0
Improved transportation to and from work	223	19.2
Respite care	132	11.4
Adult day care	117	10.2

Appendix j:

Survey Analysis

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Respite care	132	11.4
Adult day care	117	10.2

Appendix j:

Survey Analysis

Table 6 • Types of services selected by respondents who feel that there are *not* services that would assist in their care-giving role

Question #15 answered negatively, and question 16 answered (n=1,197)

Service	n=	%
Low cost meals to take home	126	10.5
Child day care	116	9.7
Improved transportation to and from work	98	8.1
Adult day care	41	3.4
Respite care	28	2.3

Notes: The combined total " n" for tables 8 & 9 does not equal 2570 due to 213 missing responses.

OPEN-ENDED RESPONSES
QUESTION # 16

A total of 359 respondents wrote additional suggestions on services that would assist in their care-giving role:

- 45 respondents made reference to accessibility issues in childcare – comments such as 24-hour childcare, on-site childcare and drop-in access after school programs for children.
- 85 respondents commented on parking issues, particularly availability of parking and the cost of parking.

Survey Analysis

Table 7 • Supports that would increase job satisfaction and/or reduce personal stress among respondents (question #19)

(n=1,160)

Service	n=	%
On-site education	1,340	52.1
Fitness programs	1,061	41.3
Increased supervisory support	1,014	39.5
Increased clerical support	1,003	39.0
Self-scheduling	821	31.9

Table 6 • Types of services selected by respondents who feel that there are *not* services that would assist in their care-giving role

Question #15 answered negatively, and question 16 answered (n=1,197)

Service	n=	%
Low cost meals to take home	126	10.5
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Fitness programs	1,061	41.3
Increased supervisory support	1,014	39.5
Increased clerical support	1,003	39.0
Self-scheduling	821	31.9

Table 8 • Further suggestions from respondents that would make the workplace more supportive (question #20)

(n=2,570)

Resource	n=	%
Increase nursing staff	749	29.1
Leadership and support from managers/ supervisors	463	18.0
Improve communication between management and staff	446	17.4
Decrease workload	404	15.7
Increase health professional staff and/or support staff	375	14.6
Employee assistance programs	350	13.6
More staff benefits	344	13.4
Support for continuing education 320		12.5
Decrease overtime	209	8.1
Improve equipment/technology	177	6.9
Create more full-time positions	85	3.3

Appendix j:

Survey Analysis

Table 8 • Further suggestions from respondents that would make the workplace more supportive (question #20)

(n=2,570)

Resource	n=	%
Increase nursing staff	749	29.1
Leadership and support from managers/ supervisors	463	18.0
Improve communication between management and staff	446	17.4
Decrease workload	404	15.7
Increase health professional staff and/or support staff	375	14.6
Employee assistance programs	350	13.6
More staff benefits	344	13.4
Support for continuing education 320		12.5
Decrease overtime	209	8.1
Improve equipment/technology	177	6.9
Create more full-time positions	85	3.3

Appendix k:

Letters Requesting Submissions

August ____, 2000

NURSING ORGANIZATIONS

Dear:

Re: Submission to the Worklife Task Force

On March 1, 2000, the Minister of Health announced the province's 5-point plan which offers a comprehensive approach to dealing with Manitoba's nursing shortage. One of the five points of the plan was the establishment of a three-person Task Force (see attached) to address issues that affect worklife of nurses. The Task Force will also identify specific pilot projects that could improve working conditions and morale.

To this end, the Task Force is seeking input from as many registered nurses, licensed practical nurses and registered psychiatric nurses as possible. In addition, we are seeking input from organizations, such as the _____, which are knowledgeable about the concerns of nurses.

If your organization is interested in making a submission to the Task Force, please provide a brief response to the attached questions, by October 31, 2000, to

Workforce Policy & Planning Unit
Manitoba Health
300 Carlton St.
Winnipeg, Manitoba R3M 3M9

Attention: Worklife Task Force

Any additional information and recommendations you might provide would be helpful and most appreciated.

Sincerely

Anne Wright

Anne Wright, Chair
Worklife Task Force

NURSES' WORKLIFE TASK FORCE

SUBMISSION

Organization: _____

Date: _____

Contact Person: _____

Name: _____

Title: _____

Telephone: _____

Fax: _____ E-mail: _____

1. During the last three years, has your organization conducted a study related to the work environment of nurses?

- If so, what were the key findings and recommendations?
- Please include a copy of the report or executive summary, if available.

2. Is your organization currently participating in studies or projects related to supportive work environments/quality of working life for nurses?

- If so, please describe briefly the initiatives and anticipated outcomes.

3. Has your organization received any additional information, which might indicate the factors that promote job satisfaction amongst nurses, contribute to job dissatisfaction and/or to stress of nurses?

- If so, briefly describe the ways in which information has been collected and the key findings.

4. What would your organization recommend to improve nurses' worklife?

Please return, by October 31, 2000, to:

Workforce Policy & Planning Unit
Manitoba Health
300 Carlton St.
Winnipeg, Manitoba R3M 3M9

Attention: Worklife Task Force

Appendix I:

Organizations Invited to Prepare Submissions

Helen Rempel, President
Manitoba Association of Licensed
Practical Nurses
2nd – 1601 Regent Avenue
Winnipeg, MB R3C 2B3***

Linda Kulkarni on behalf of Pat Cockburn
Chair
Provincial Health Programs & Services
Executive Network***

Cheryl Adams, President
Registered Psychiatric Nurses
Association of Manitoba
1854 Portage Avenue
Winnipeg, MB R3J 0G9***

Dr. Tony Bos, President
Keewatin Community College
Box 3000
The Pas, MB R9A 1M7***

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